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Cancer and its Treatment

By G. E. RICHARDS, M.B., Director, Department of Radiology, Toronto General Hospital; Associate in Radiology, University of Toronto.

Few persons ever stop to realise what a wonderful mechanism is that which controls the growth and repair of tissue in the human body. This mechanism it is which determines for example that when the body is cut or injured so that tissue is lost, new tissue is produced to make up for this loss *and no more*; that as the various tissues wear out, new cells are developed to replace them, just enough cells for the purpose *and no more*; thus the body is able to carry on its duties and make its own repairs throughout the long years of life in a truly marvellous manner. All of these changes are subject to the mechanism which controls the building up and breaking down of cells so that a very exact balance is maintained. Under certain conditions, however, some cells commence to grow independently of this mechanism so that the rate of growth of these cells is out of all proportion to the needs of the body *and is beyond the control of the body*. Such an overgrowth of cells is what is commonly referred to as "cancer" and it is capable by its overgrowth or by invasion of other tissues and dissemination to distant parts of the body of ultimately destroying the individual.

Viewed with the microscope a section of normal tissue may be compared somewhat to a section of honeycomb in which each cell is complete in itself and has definite boundaries which it recognises and adheres to closely. Cancer tissue, on the other hand, while composed of similar cells recognises no such boundaries, but invades the surrounding tissues regardless of whether these are muscles, fascial planes or even bone itself.

Thus, the two outstanding characteristics of cancer cells are: first, their property of invasion of surrounding tissues and, secondly, their property of dissemination to remote parts of the body. When these cells become so disseminated they immediately commence to grow and produce in this new spot a growth very similar in its make-up and other characteristics to the parent from which the cells originally came. Such a growth is then known as a "secondary" cancer.

Varieties of Cancer

For the purpose of our present discussion it is sufficient to recognise two great groups or varieties of cancer: (1) Carcinoma, which is a cancer cell originating in epithelium, i.e., skin or mucous membrane, covering structures of the body; (2) Sarcoma. Of these there are several subdivisions as there are of carcinoma, but it is sufficient to say that sarcoma is a malignant growth originating in the connective or supporting tissues of the body.

What Do We Know of The Causes of Cancer?

While we know a very great deal about the varieties of cancer, its habits of growth, and life history, we do not know the specific cause, or what it is which starts this overgrowth in the first place. *First*, cancer never develops in perfectly health tissue. There is always some abnormality present and this is frequently present for a very considerable length of time before the cells definitely change from simple unhealthy cells to definitely malignant ones. *Second*, in the beginning cancer is always a local disease; in some parts of the body this is very easy to observe and verify. In some organs it is more difficult to verify, and yet, all the available information confirms the statement just made.

We now have a considerable accumulation of information regarding some varieties of cancer tending to show that irritants play an extremely important part in its production:

(1) *Heat*: A good illustration of the manner in which heat can act as an irritant ultimately leading to the formation of cancer is found in certain people in the mountains of India. In these regions the cold is very intense and the people are in the habit of carrying a small basket containing live coals of charcoal against the abdomen inside their sheep-skin coats. These are worn over long periods of time and ultimately a considerable number of these people develop cancer of the skin of the abdomen directly at the point where the heat has been present over a long time.

(2) *Cold*: In this country we frequently make the observation and a similar one has been made amongst the sailors of the North Sea, that epithelioma develops along the skin of the ear in the site of frost bites.

(3) *Chemical Causes*: One of the classical illustrations is the development of cancer of the skin in chimney sweeps in England, due to the irritation from the soot to which they are exposed. Similar cancers occur in those who are exposed to various kinds of tar in manufacturing processes and in certain oils in the spinning of wool. An extremely interesting example occurs in the aniline dye factories in Germany. Workers who are exposed for a number of years to the aniline dyes in these factories frequently develop cancer of the bladder and this has been noted in many cases even years after the workers had left the factory. The percentage of cases is so high as to be definitely recognised as having a connection with the aniline dye industry.

(4) *X-rays, Radium and Sunlight*: These are three forms of energy which differ from each other only in wavelength and all are capable of causing cancer of the skin by long continued exposure. In many parts of the world

rodent ulcers and epithelioma of the skin are very common in individuals who are exposed to the irritating effects of sunlight for very long periods of time. This is particularly true in Australia, especially with fair-haired individuals. In connection with x-rays and radium, many of the early workers have paid with their lives and this danger is now well known and should be adequately guarded against. It is the long continued exposure to small amounts of both of these such as occurs in the fingers of those who are called upon to work with them. There is no danger under proper conditions to patients undergoing treatment.

(5) *Septic Teeth, Tobacco, etc*: It is extremely rare to see a cancer in the oral cavity in an individual who has healthy teeth and a clean mouth. Cancer in the oral cavity commonly develops in some location where the tissues are being constantly damaged by a jagged tooth, an ill-fitting plate or are being irritated by dirty septic teeth or the effect of tobacco or syphilis.

(6) *Trauma*: There seems to be undoubtedly a relationship between trauma and cancer, although this must be extremely rare since all of us are constantly receiving small injuries which might otherwise result in cancer with disastrous results to the human race.

Most other theories of the cause of cancer are more or less speculative and it is along this line that the most intensive research is being conducted at the present time. It is quite possible that the cause of cancer may prove to be multiple and differ for different forms of cancer in different organs of the body. And without any thought of discouraging the intensive research which is being carried out, it is only right that we should realise the fact that the discovery of the cause of cancer might not lead immediately nor even directly to any certain cure for the disease. The discovery of the cause of tuberculosis did not lead

immediately to a discovery of its specific cure and the progress which has taken place in this disease has had little benefit from the knowledge of its cause, whereas, this knowledge has benefited immensely along lines of prevention, and the protection of others from those afflicted with the disease.

Is Cancer Contagious?

There is absolutely no evidence to indicate that cancer is contagious or infectious, or in fact that it is transmissible from one individual to another and this is a fact which should be emphasized by the nursing profession to the public in every way possible.

Is Cancer Increasing and What Is To Be Done About It?

Undoubtedly cancer is increasing. Statistics show that it has increased from 25 to 40 per cent. in the last twenty years. There are many ways of explaining this, but it seems better frankly to admit the fact that the disease has increased and should be regarded as a definite menace in every community. It is probably not far from the truth to say that 10 per cent. of deaths in adult males and 15 per cent. in adult females are due to cancer. If this is so, what is being done, or what more can be done to meet the situation?

If, as we have stated, we do not know the cause of cancer, and if it is neither contagious nor infectious, how then may we hope to accomplish anything along the line of prevention? There is probably no field in which the nursing profession can be of greater value than in this very field of activity. Since cancer in its early stages is localised, and can be cured in a high percentage of cases by eradicating this localised growth, it is scarcely possible to over-emphasize the benefits which may follow from the dissemination of this knowledge and prompt action along this line. This involves the early recognition and adequate treatment of all pre-cancerous lesions. There are a num-

ber of organs in the body in which this is beyond our reach, but the following indicates those in which it is very easily within our reach and in which much may be accomplished in the way of prophylaxis.

(1) *The Skin*: Warts, moles and keratoses generally should be regarded with suspicion from middle life onwards and should be recognised as pre-cancerous lesions and dealt with accordingly. If they give evidence of increasing in size, becoming irritable or otherwise changing their character they should be treated at once. Black or pigmented moles are especially dangerous and should be eradicated either by wide excision or by electrical destruction followed by radium treatment.

(2) *The Lip and Mouth*: On the lip any crack or fissure, keratosis, fever blister, or superficial ulcer which does not respond to simple treatment and heal in a comparatively short time, should be regarded as a potential cancerous lesion and treated accordingly. At this stage not less than 95 per cent. and usually 100 per cent. of these lesions can be permanently cured, and if this were done none of them would be allowed to develop into true cancers. Even though a few did develop if they are accurately recognised as malignant lesions, the majority could still be cured either by excision or by radium or x-ray treatment.

(3) *Lumps in the Breast*: Many women with a lump in the breast fail to report to their doctor because of the fear that he will advise an operation. It should be emphasized to the public that an operation should only be a thing to be feared if done too late. If the public knew the following facts it would probably do much to remove this fear. Operation for cancer of the breast, if the disease is limited to the breast, succeeds in more than 70 per cent. of the cases in completely curing the patient. At this stage there is nothing to fear, but if the disease is neglected until it spreads beyond the breast, the per-

centage of cures falls off very rapidly and is certainly not greater than from 20 per cent. to 30 per cent. Patients should be urged to report at once the discovery of a lump in the breast or of a blood stained discharge from the nipple. They should be informed that cancer is only painful in its later stages and that therefore, because a lump is not painful is no reason for considering it of no importance.

(4) *Lacerations of the Cervix*: This is perhaps more directly the province of the family physician but the nursing profession can do much by encouraging women in general to have lacerations of the cervix repaired and cervical diseases removed, particularly after the child-bearing period has been passed.

(5) *Bodily Hygiene*: It is a mere truism to say that people neglect their bodies outrageously. Many people give less attention to their bodies than they do to animals who serve them or machines which work for them. The mouths of many people who report with carcinoma are simply filthy. If these were their backyards, the health authorities would have them cleaned up; but since they are personal properties, no outsider can interfere.

Constipation is another evidence of neglect of the body and it should be corrected, preferably by a proper selection of food, but in any case it should be corrected.

Thus, by a thorough system of cleanliness and care of the body, a very great deal can be accomplished in cancer prevention. Next to this comes early recognition of those slighter departures from the normal which are the border-line stages and which should be removed. Fads should be discouraged and the public should be informed, for example, that so far as we know there is no direct connection between any particular diet and the occurrence of cancer. Cancer occurs in those who eat meat and those who do not. It occurs in those who are civilised and those who are not. It occurs amongst the lower

animals, such as dogs and wolves, whose diet is largely meat, and in rabbits whose diet is solely vegetarian. It occurs commonly among fish and is quite common among plants both in the wild state and in a state of cultivation.

Treatment

There are only a few agencies which are of value in the treatment of this disease and all sorts of experiments have been tried and have failed to bear the test of time. Among those which have failed up to the present are the various sera. "There is no drug or serum known which can cure cancer and anyone who claims secret knowledge or advertises such a cure should be regarded as a 'quack'." A few years ago much was expected from the use of colloidal lead but this has failed to stand the test of time. Caustic pastes have been used for generations as a remedy for cancer and in the superficial varieties of this disease in their time they had an important place. At the present time they are antiquated measures which are crude and not to be compared with the modern means of dealing with the disease. Of these there are only three, viz: first, surgery; second, cautery methods; third, x-ray and radium. Surgery has for many years been the sole method of dealing with cancer and still occupies the first place. Various cautery methods have their place in dealing with certain types of accessible lesions. X-ray and radium are newer and have made important progress in the past few years. They both have very definite indications and definite limitations which it is important to recognise, but both are progressing rapidly and from them much further improvement may be expected.

What May Be Expected in Treatment By Radium and X-ray?

(1) *Skin Lesions*: Almost 100 per cent. of skin cancers should be cured under present conditions. Failures now occur practically entirely in those cases which have been neglected until

they have extended deeply under the skin or have involved bone or cartilage, or which have been unsuccessfully treated by caustics or by x-rays or radium. It is extremely important in this as in most other cases of cancer that the first treatment should be successful. If it fails the tissues undergo changes which make subsequent treatment more difficult and may make a cure impossible.

(2) *The Oral Group*: Cancer of the lip in which no glands are involved should be cured in about 90 per cent. of the cases, but if the glands are involved at the time of treatment, the percentage of cures is much reduced and probably does not exceed 50 per cent.

Cancer of the Tongue: The results of treatment vary depending upon the location of the lesion in the tongue and also upon whether or not glands are affected. At the tip of tongue, cancers can be cured in about 40 per cent. to 50 per cent. of the cases, whereas at the base of the tongue the percentage of cures is between 10 per cent. and 15 per cent. In the tonsil the percentage is about 25 per cent., and on the back of the throat it is between 40 per cent. and 50 per cent. This location is slightly more favourable because it does not tend to become disseminated quite so early.

Progress is being made quite rapidly in this group of cancers, and with earlier recognition and more skilful treatment it may be expected to be greatly improved in the next ten years.

(3) *Cancer of the Uterus*: Here again everything depends upon early recognition and adequate treatment. The best figures show that the average curability of carcinoma of the cervix is about 50 per cent. if it is treated early and 17 per cent. or less if treatment is not undertaken until the disease is well advanced. In these days when frankness is considered a virtue, every woman should understand that bleeding between menstrual periods, or bleeding after

the menstrual function has stopped, demands investigation, and she should not rest content until she has been thoroughly examined and the cause of the bleeding discovered.

(4) *Carcinoma of the Breast*: If the disease is recognised early and operated upon while it is still limited to the breast, about 70 per cent. of cures will be obtained. Under these circumstances there is little field for x-rays or radium, but if the disease has been neglected and allowed to extend beyond the breast into the glands of the axilla or elsewhere the percentage of cures by surgery alone drops to between 20 per cent. and 30 per cent., and here the use of x-rays following the operation is of the greatest possible value and has been the means of raising the percentage of cures on an average between 25 per cent. and 50 per cent., i.e., the addition of properly administered high voltage x-ray treatment following the operation increases the patient's chance for a cure not less than 25 per cent., and some writers even claim as high as 50 per cent.

Conclusions:

Those who are closest to the problem and are in a position to see both the successes and failures feel that there is increasing ground for hopefulness, in spite of the fact that figures indicate an increase in the rate of cancer. There is not the slightest doubt that our facilities for dealing with this terrible disease are more effective than they have ever been and are steadily being improved. Certainly more patients are being cured than ever before, and this is being accomplished with less mutilation and infinitely less suffering. The watchword of the medical and nursing professions should be "early, accurate diagnosis and prompt, efficient treatment." There is no place in this work for the amateur or the charlatan, both of whom have been altogether too prevalent in the past.

Editorials

Courage and Optimism

The years 1930 and 1931 will go down in history as years marked by general economic depression and unemployment. To this will be added, in some parts of Canada, a record of unprecedented drouth and crop failure. From the distress and disruption consequent upon such conditions no part of the population can hope to be entirely exempt. Canadian nurses are today feeling the strain occasioned by the chaos of such world conditions.

It is not impossible to find records of previous periods of a similar nature of depression through which the nursing profession has passed, nor is it impossible to find records of the courageous spirit with which such periods have been faced. Happily, it does not appear to be our nature to dwell upon past difficulties. They are fairly readily forgotten. Depression of mind, too, quickly disappears when the first signs of returning prosperity are seen. Perhaps this thought may hold some cheer at this time!

The past decade has marked much progress in nursing. The education of the student nurse is becoming organised on a more accepted educational basis; graduate study is definitely provided in leading universities; public health work is growing steadily in both official and voluntary organisations, and, very important indeed, a growing knowledge of health needs, on the part of the people, has brought about a most insistent public demand for health service. True, the progress made is only a beginning and much hard work remains, pioneer work in many things, as we shall undoubtedly be informed by the Report of the Survey of Nursing in Canada. The Survey in itself indicates progress, since a desire to seek out faults and to correct them can only have come from a deep knowledge of the needs of nursing education and of the possibilities for service in nursing. Nurses in the next decade will have cause to

thank the leaders of today whose insight, clear thinking and ability to follow thought with action have made the Survey possible.

Out of the progress in nursing in recent years ideals have gradually been formulated—ideals of service, ideals of organisation, ideals of qualification, and the standards which have been set up and which represent these ideals are quite definitely the outcome of knowledge and experience. Whatever the burden which present economic conditions may place upon us, there must be no suggestion that these standards and ideals should be lowered even in the slightest degree. To accept a lower standard even temporarily may be retrogression. To maintain standards and to cling persistently to ideals, while showing outwardly less advance, may be the finest type of progress. It requires courage, at least, and courage, J. M. Barrie says, is "the lovely virtue" and "comes all the way".

In many parts of Canada this year, nursing in all its branches is confronted with conditions which must inevitably retard for a time the expansion and development which have been indications of progress. With financial conditions as they are it is impossible that it should be otherwise. At the same time there is an equally inevitable increase in the need of the people for the service we can give, since poverty and destitution have always in their wake a never-ending line of physical ills. To secure more service for a needy people, with a much reduced budget from which to supply it, is the difficult task facing many nursing organisations today. How it will be done remains to be seen, but it must be admitted that all the ability, all the determination and all the faith of which administrators are capable will be required for the task. Of the outcome there can be no doubt. Canadian nurses will meet the situation successfully and with an unfailing spirit of optimism.—R.M.S.

Child Psychology and the Child-Parent Relationship

No greater opportunity is presented than that which comes to the community nurse, particularly to those in the public health group. I have reference to the child psychology and the child-parent relationship study, and speak as one, not in authority, but as a graduate nurse and mother, who has realised far-reaching results through having developed a better understanding between child and parent. Our children are the greatest heritage we possess, and many mothers, after becoming interested in study-groups and reading literature pertaining to child psychology, have remarked, "I never realised before what a privilege it was to mother a family. I had regarded it as a condition having been thrust upon me."

For a nurse to interest herself in this subject, sufficiently to radiate her influence among her contacts, an extensive course is not necessary. In the larger centres, where a course is available, one is fortunate indeed to avail oneself of the opportunity, and I would stress the point of studying child psychology, if for no other reason than in later years applying it to one's own children. Surely nothing is more important than the mental health of a child. Far too few parents realise that, during the first seven years, the child's life in their care is as pliable as putty—theirs to make or mar—maybe through only one of the many traits, viz., that of creating an inferiority complex, a handicap that increases with adult years, and that could easily have been avoided. If, as we are told by one poet, life is made worth while by helping one fallen robin back into its nest again, how much greater is our opportunity of preventing a child from leaving the home-fireside?

The public health nurse who has qualified to introduce this subject to an understanding mother can feel that she has accomplished her good deed for the day, for it is like the pebble cast into the ocean, with its ever-increasing circles.

The interested mother is not necessarily a university graduate. She acts as a leader, not in the capacity of an authority, to provide a prescription, as it were, but to encourage discussion, and through that medium to establish a principle that may be adopted in any household. It is so comforting to return home realising that one's child is not unusually naughty, merely normal, and one's problems are shared by others. One realises, as maybe never before, that however small the child, it also has a personality, possessing viewpoint which deserves interpretation.

The following quotation proved the means of convincing one mother to act as a group leader, and she said never again did she "shout" at her children, no matter how worried or flurried:

"THE TONE OF VOICE"

It is not so much what you say,
As the manner in which you say it;
It is not so much the language you use,
As the tone in which you convey it.

"Come here!" I sharply said,
And the baby cowered, and wept.
"Come here!" I cooed, and she looked
and smiled,
And straight to my lap she crept.

Whether you know it or not, whether you
mean or care,
Tenderness, kindness, love and truth, envy
and anger are there.
So if you would quarrels avoid, and in
peace and love rejoice,
Keep anger not only out of your words,
But keep it out of your voice.

M. E. H.

Windsor Special Treatment Clinic

By CORA APPERLEY, Social Service Nurse, Special Treatment Clinic, Windsor, Ont.

Previous to the war of 1914-1918, the problem of Venereal Disease control had received very little attention in Canada. However, conditions uncovered in the army made it imperative that some steps be taken. In 1917 the Ontario Government appointed a Royal Commission of Investigation, with the result that, in 1918, the Venereal Diseases Prevention Act was passed. The main provisions of this Act were:

Reporting of new cases by serial number;

Compulsory examination of (a) persons under arrest or in custody; (b) upon receipt of credible information;

Prescribing course of conduct, (a) sex conduct, (b) treatment;

Detention of infected persons;

Prohibition of treatment by unqualified persons;

Prohibition of advertisement of cure; Requiring hospitals to provide facilities for treatment;

Enjoining secrecy on persons administering Act.

The Local Medical Officer of Health is responsible for the enforcement of this Act.

The Federal Government voted a certain sum of money to be used to establish and carry on clinics throughout the provinces, the money to be divided according to population, on condition that a like amount be provided by the provinces. Ontario agreed to this, and at the present time there are eighteen clinics within the province. Windsor was chosen as the site of one clinic.

The Border Cities, situated on the shores of the Detroit River directly across the line from Detroit, is an automobile centre. It is comprised of six municipalities (Riverside, East Windsor, Walkerville, Windsor, Sandwich and Ojibway) each with its own municipal organisation except for union under a joint Board of Health. The

total population is 112,109, of which approximately 12,500 are aliens. Predominating among the aliens are Russians, Poles, South-Eastern Europeans and Chinese. There is also a high percentage of transients, due to the fact that it is so close to a port of entry to the United States. Windsor, the largest of these municipalities, has a population of 68,079, and of these 6,910 are aliens. About 25% of the total population of the Border municipalities is French-Canadian, this being one of the earliest settlements when Canada belonged to France.

Windsor Special Treatment Clinic was opened in July of 1920, with Dr. A. L. Poisson as Medical Director. Dr. Poisson, a graduate of the Medical School of the University of Western Ontario of 1914, is a specialist in Urology, and spent three years during the war with the Canadian Army Medical Corps in England and France.

In June of 1921 a full-time graduate nurse was appointed. Her duties were to wait on the doctor, admit patients, and do the follow-up work. The staff at this time consisted of a doctor, nurse and an attendant.

The first site of the clinic was the third floor of a down-town office building, and consisted of four small rooms—a waiting-room accommodating about ten persons, an office and two small treatment rooms. During July, eight patients were treated, with a total of twenty-eight treatments given. In August, twenty-one patients and eighty treatments given. The clinic grew steadily, as can be seen from Charts Nos. 1 and 2. The rooms soon became too small to accommodate the patients coming, and in 1923 space was taken in another office building. A laboratory and irrigation room were added, and the waiting room and treatment rooms were much larger than before. At this time 249 active cases were being cared for and an

average of 500 treatments given per month. In 1924 the work became too heavy for one doctor, and an assistant was appointed (part time). More space was taken in 1926 and the rooms were again enlarged. Again in 1929 more space was taken, giving a floor space of 1,500 square feet. The cubicle system was installed at this time. At the present time there are 405 active cases listed and an average of between 80 and 90 treatments per clinic being given. Four clinics of two hours each are held per week. The hours are so arranged that the patient may come from work, get his treatment and go home without anyone knowing of his call. The clinic, situated always in an office building and never in hospital, is a help to the patient in keeping the knowledge of his infection a secret.

The staff now consists of two doctors (part time), two full-time nurses and one part-time nurse (all graduate nurses).

There is no fee for treatment received. The object of the clinic is to give the patients adequate treatment, and treatment until they are cured or pronounced non-infective by the physician in charge. Although no patient is refused treatment whether he can pay or cannot pay, at least 95% are not in a position to pay for sustained treatment.

Patients on admission are interviewed by the social service nurse, after which they are seen by the physician in charge. When the diagnosis is made, this history is taken. The patient is instructed with regard to his own health: his diet, the danger of alcoholic drinks, etc. He is advised as to the care he must take for the protection of others, such as using his own towels, drinking cups, and his conduct. A written copy of instructions for conduct while under treatment is given, with an explanation of the penalty for violation of these rules. As far as possible, all contacts of the patient as well as the source of infection are located and examined.

The waiting room has been made as attractive as the funds will allow, with plants, magazines, health posters, a

lending library and a few pieces of wicker furniture. The name on the door of the waiting room reads: "Special Treatment Clinic," and this is as the clinic has always been known rather than a Venereal Disease Clinic.

In the Border Cities there are 120 medical practitioners. Of these, 25% have referred indigent cases to the Board of Health during 1929 and 1930, while 5% reported the defaulters. The term "defaulters" is used in connection with patients who have violated the Venereal Diseases Prevention Act.

Since the opening of the clinic many problems have arisen, some requiring the enforcement of the law, such as patients discontinuing treatment while still in an infectious condition, or patients found to be disobeying the instructions given them, etc. In many cases the former defaulters have been located through the Courts, as very often these people are law-breakers. We have always received splendid co-operation from the police magistrates and the police and immigration departments.

Many of the syphilis contacts are found in the patient's family, e.g. wife and children. In gonorrhoea the most of the cases are single men and young single girls.

In 1930 there were 91 persons examined who were found to be free from venereal disease at the time of examination.

TABLE No. 1

SHOWING SOURCES OF NEW CLINIC PATIENTS

	1928	1929	1930
Social Agencies.....	--	10	13
Patients (friends and family).....	8	3	2
Came voluntarily.....	93	74	66
Referred by Physicians...	45	41	34
Referred by Courts, Police, etc.....	15	5	8
Referred by Hospitals and Institutions.....	5	--	1
TOTAL.....	171	133	124

These patients were referred to the clinic without having had any previous treatment.

THE CANADIAN NURSE

TABLE No. 2
SHOWING ADULT ADMISSIONS TO CLINIC

	New Cases			Re-Admissions			Previously Treated Elsewhere		
	Gono.	Syph.	*D.I.	Gono.	Syph.	*D.I.	Gono.	Syph.	*D.I.
1928—TOTAL.....	101	47	16	14	14	2	11	18	2
Male.....	83	20	6	12	7	1	8	10	1
Female.....	18	27	10	2	7	1	3	8	1
1929—TOTAL.....	73	55	8	15	34	1	18	27	4
Male.....	56	36	3	11	26	0	11	15	2
Female.....	17	19	5	4	8	1	7	12	2
1930—TOTAL.....	87	29	7	39	30	1	37	39	4
Male.....	59	16	3	27	18	0	29	29	--
Female.....	28	13	4	12	12	1	8	10	4

*D.I.—Double Infection.

TABLE No. 3
SHOWING ADMISSIONS OF CHILDREN TO CLINIC

	New Cases		Re-Admissions		Previously Treated Elsewhere	
	Gono.	Syph.	Gono.	Syph.	Gono.	Syph.
1928—TOTAL.....	2	6	1	1	--	1
Male.....	--	2	--	--	--	--
Female.....	2	4	1	1	--	1
1929—TOTAL.....	3	2	1	1	2	--
Male.....	1	1	--	1	--	--
Female.....	2	1	1	--	2	--
1930—TOTAL.....	3	3	1	--	5	4
Male.....	1	2	--	--	1	4
Female.....	2	1	1	--	4	--

TABLE No. 4
SHOWING PATIENTS DISCHARGED DURING 1930.

	Gono.	Syph.	D.I.
Apparently cured:			
TOTAL.....	111	23	9
Men.....	83	16	3
Women.....	24	5	6
Children.....	4	2	--

TABLE No. 6
PATIENTS REFERRED FROM THE CLINIC TO PHYSICIANS, INSTITUTIONS, OR OTHER CLINICS FOR TREATMENT DURING 1930

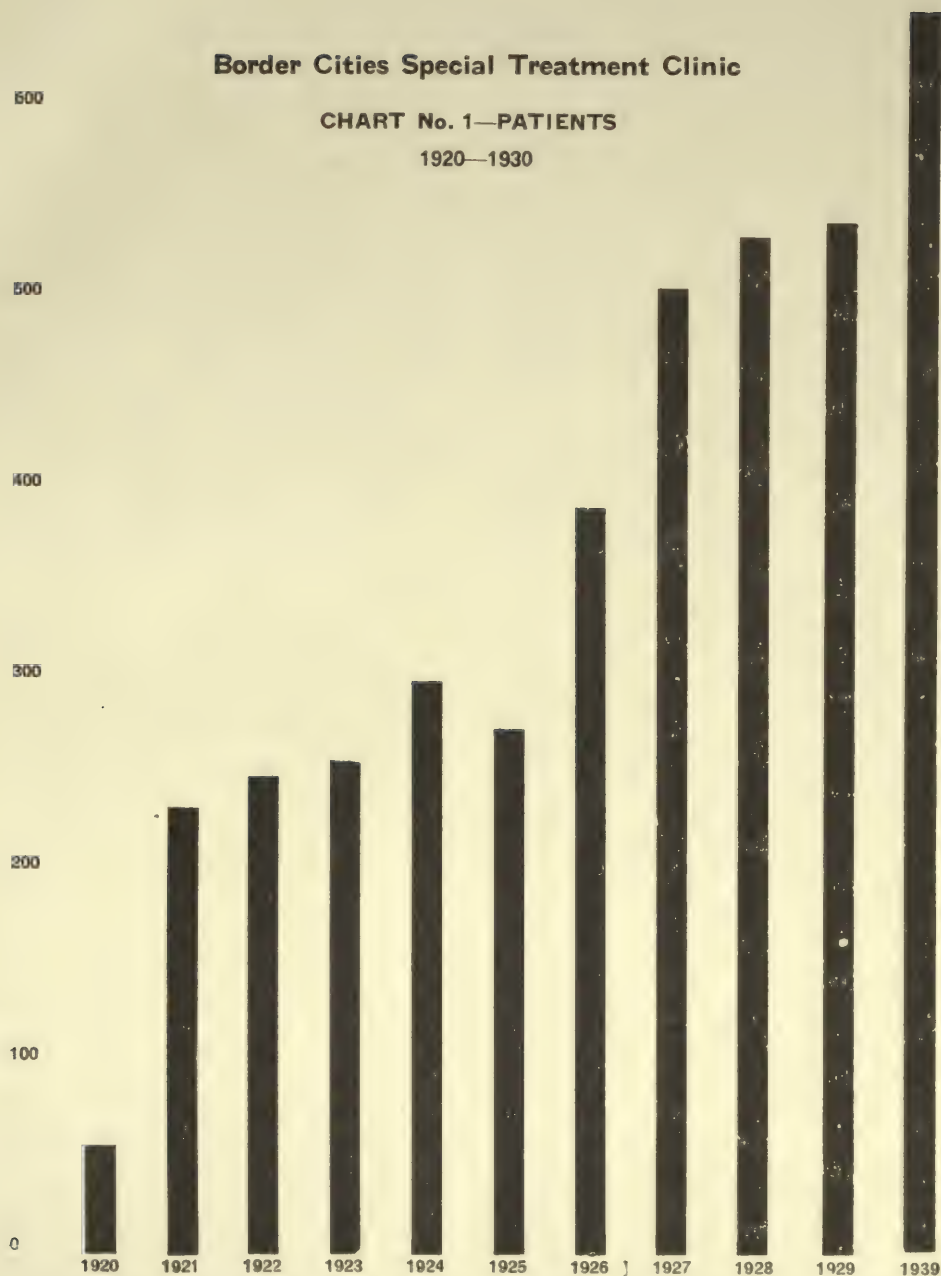
	Gono.	Syph.	D.I.
TOTAL.....	32	59	15
Men.....	18	31	6
Women.....	12	27	9
Children.....	2	1	--

TABLE No. 5
SHOWING PATIENTS LOST DURING 1930

	Gono.	Syph.	D.I.
TOTAL.....	15	24	1
Men.....	7	16	--
Women.....	6	6	1
Children.....	2	2	--

TABLE No. 7
SHOWING NUMBER OF CONTACTS LOCATED, EXAMINED, AND PLACED UNDER TREATMENT DURING 1930

	Gono.	Syph.
TOTAL.....	74	26
Male.....	50	12
Female.....	22	11
Children.....	2	3



Border Cities Special Treatment Clinic

CHART No. 2—TREATMENTS

1920—1930



The Story of Diphtheria

By H. B. CUSHING, M.D., Montreal.

Diphtheria is one of the most ancient of recognised epidemic diseases, being apparently known to Hippocrates 300 years before Christ and first definitely described by Aretaeus about 100 A.D. Aretaeus was a contemporary of Galen and has left us a very clear picture of an epidemic of diphtheria. He described it as more common in children and characterised by a moist substance forming over the tonsils with a putrid odour, leading to a husky voice and suffocation. Diphtheria was recognised early in America, and described by W. Douglas (1736) as a new epidemic in Kingston, near Boston, and called *angina ulcerculosa*. Bard (1771), professor of practice of physic in King's College (now Columbia University), New York, gives a classical description of the disease as *angina suffocativa*. George Washington was supposed to have suffered from it at Mount Vernon.

In France, Napoleon Louis Charles, eldest son of Louis Bonaparte and Hortense Beauharnais, died of croup at the age of four years in 1807. He was Napoleon Bonaparte's godson and nephew, and the great general with his characteristic energy immediately offered a prize of 12,000 francs for the best essay on croup. This proved as sterile of real results as such prizes have always been; seventy-nine essays were sent in, none showing originality, and the prize was divided between Louis Jurine of Geneva and J. A. Albers of Bremen. Probably all the contestants published their essays, for in the first quarter of the nineteenth century over 100 treatises on the subject were published, but one searches in vain for any new ideas or even new facts of clinical observation well recorded.

The modern conception of diphtheria really dates from the classical

monograph of Professor Bretonneau, published in 1826. His great work consists of a series of memoirs, giving for the first time an accurate description of diphtheria as a contagious disease, with its detailed pathology, diverse symptoms and course, its identity with croup, and giving it a name diphtheritis, from *diphthera*, a membrane.

Pierre Bretonneau was one of the great masters of medical history. He was the first to differentiate both diphtheria and typhoid fever. He was an ardent and indefatigable worker, used to make ward rounds in his hospital every morning at six o'clock, and personally performed autopsies on every available case. He was a great teacher in the clinical style rather than a lecturer or writer. He was not very popular with the local practitioners of Tours, who denied his teachings of diphtheria and the existence of any epidemic. It is recorded that when he failed to obtain their permission to demonstrate the disease by autopsy on some of their cases, he went out at night, accompanied by the faithful Velpeau, and dug up two or three of the corpses and performed hurried autopsies to prove they died of the disease he had described. Being discovered on these nocturnal expeditions, he was shot at and narrowly escaped with his life. This sort of thing did not make him any more popular, and for decades the local medical society refused to recognise his work or use his names for diphtheria and typhoid, though all the rest of the medical world had adopted them.

Probably the most interesting of the case reports in his great memoirs is the famous case of Elizabeth de Puysegur. This was a little girl of four years, whom he describes as the remaining daughter of his dearest friend, the Comte de Puysegur. The count had already lost three children by diphtheria, and when the remain-

ing child threatened to suffocate like the others with laryngeal involvement, Bretonneau saved her life by the first recorded successful tracheotomy in diphtheria. As one reads the detailed case report one wonders how she happened to recover, for Bretonneau started treatment with an emetic, then cauterized the throat with concentrated hydrochloric acid, then ordered two grains of calomel every two hours, with occasional doses of jalap and castor oil. He afterwards increased the calomel to every hour. He performed the operation on the sixth day, having postponed it until the last possible moment, and used a tube of his own devising. He blew more calomel down the tube at frequent intervals, but found this caked and blocked it. She expelled casts of the trachea and bronchi through the wound, but eventually recovered and later married and became rather a famous personage, the Comtesse de Billy.

Although Bretonneau's work was far in advance of anything previous, there are naturally many errors and omissions in it. He confused ulcerative stomatitis with diphtheria and did not recognise the effect on the heart or post-diphtheritic paralysis, etc., yet for the first time he established the disease as a recognisable entity.

After Bretonneau comes a long period of confusion: the first stage of recognition and definition of the disease was reached, but so long as there was no exact knowledge of the cause or accurate means of diagnosis there was constant controversy. Thus we find Bretonneau's great pupil, Trousseau, trying to distinguish diphtheria and croup as separate diseases, although he added items to our knowledge, especially about the effects of diphtheria on the nervous system and the heart. He changed the name diphtheritis to diphtheria. Even the great Virchow, the father of pathology, published an able article in 1847 to prove that diphtheria and croup were two different processes,

chiefly because the membranes in the trachea and bronchi were always loose and caused no necrosis of the underlying mucosa.

Not only was there confusion as to what was included under the specific disease, but also as to the manner of its spread and whether it was infectious or not. Thus we find many trying to reproduce false membranes by artificial means, such as irritant substances. Bretonneau himself, although convinced it was contagious, confesses that his attempts to induce the disease in animals were negative. Trousseau and Michel Peter, who succeeded him, both tried to inoculate themselves on the arms and on the tonsils with pieces of false membrane, but unsuccessfully, presumably being immune like most adults.

The third period comprises the discovery of the organism causing diphtheria and the study of its peculiarities and effects on animals and man, at last affording us an accurate scientific knowledge of the disease and a test for diagnosis. It is interesting that all these further advances were made not by practising physicians, but by scientists devoting their whole time to research. They were chiefly inspired by and worked in the institutes founded by Koch in Germany, and Louis Pasteur in France. The actual discovery of the diphtheria bacillus was made by Professor Edwin Klebs in 1875. He was one of the earlier assistants of Virchow and credited with many bacteriological advances. He demonstrated the organisms in sections of the false membranes, but did not grow them or produce the disease by their means. Many other organisms had been described previously as the cause of the disease, cocci, fungi, organisms in the blood, etc., so Klebs' announcement did not attract much attention at the time. Friedrich Loeffler (1852 to 1915), an assistant of Professor Koch, issued in 1884 his exhaustive and epoch-making work on the diphtheria bacillus. It is one of the classics of bacteriological science and a triumph

for the doctrines and technique laid down by Robert Koch. He grew the organisms on his own medium, stained them by his own preparation of methylene blue, inoculated them in animals, and showed how cultures might be used for the identification of the disease. Loeffler's work was almost immediately confirmed and the differentiation of the disease and the manner of its transmission established.

The next great advance in the treatment of diphtheria was the introduction of intubation in 1888. This life-saving operation we owe entirely to the genius and painstaking industry of Dr. Joseph O'Dwyer, of New York City. Dr. O'Dwyer (1841-1898) was born in Cleveland, Ohio, spent his boyhood and was educated in Ontario, near London, and afterwards went to New York for his medical education. In 1872 he started practice in New York and was appointed to the staff of the New York Foundling Hospital, where he worked for twenty-five years. He almost immediately became interested in diphtheria, which was rampant in the institution, and especially in the laryngeal cases. He was particularly discouraged with the results of tracheotomy; in fact, he says that in the first ten years of his service no tracheotomy case survived, and half the staff would not permit it to be performed on their patients, rather letting them die in peace so far as that was possible with such a dreadful disease. He soon conceived the idea, as had a number of others, of passing a tube through the throat into the windpipe to enable the child to breathe, and he worked industriously for twelve years at the problem of making a suitable tube. Needless to say, he had many discouragements, and it was eight years before he succeeded in saving a case. There was bitter opposition in his own hospital, where he was accused of experimenting on the babies. Many of the mothers removed their infants for them to die at home rather than let Dr. O'Dwyer put tubes in their

throats and hasten their end. The New York Foundling Hospital still exhibits his early tubes and many casts of larynges, etc., made in his painstaking endeavours. His first idea was a bivalve speculum to open when in position, then a small straight tube, then he gradually introduced the swellings which enabled the tube to be retained. In 1888 he presented the profession with the intubation apparatus practically as used to the present day. As usual with any innovation, it was slow of acceptance. Most of those trying intubation being clumsy and inexpert failed, so that even in the last few years text-books issued by authorities in Great Britain say tracheotomy is more satisfactory. However, he lived to see intubation generally adopted in America and to see the introduction of the antitoxin treatment, which he eagerly took up, though many of his contemporaries were discouraged by the complications induced by it. His great discovery has resulted in the saving of thousands of children and is only recently being gradually replaced by other more modern methods.

The next stage, the discovery of a specific treatment of the disease, was inaugurated by two Frenchmen, Emile Roux and Alexandre Yersin, working at the Pasteur Institute. They laboured for a number of years at the subject and published the results of their work in three Memoirs between 1888 and 1890. They succeeded in isolating the toxin of diphtheria by filtering cultures of the organisms, and studied the effects of the toxin on animals, showing how the symptoms and after-effects of the disease were produced. This paved the way for the discovery of diphtheria antitoxin, which we owe to a German professor, Emil von Behring. He was born in 1854, and became a Prussian army surgeon, and later a pupil of the great Koch. After 1888 he worked in Koch's Institute in Berlin, and it was while working there with Kitasato on the toxins of diphtheria and tetanus that he demon-

strated that the blood of animals immunised by successive doses of attenuated toxins could be used as a preventive and therapeutic inoculation against the disease in other animals. This was published in 1890, but not until 1894 was the antitoxin prepared on a large scale for use in man.

The world-wide enthusiasm aroused by this discovery is familiar to all. It was thought that a specific had been found for the cure of all infectious diseases, all that was necessary was to discover the various organisms, immunise animals and use their blood serum. Unfortunately, all know how this expectation has failed and the peculiar combination of circumstances that make diphtheria antitoxin so efficacious. Its use was quickly adopted all over the world, but at first caused disappointment and bitter opposition. The original dose of 1,000 units, supposed to be sufficient for any case, we now know to be totally inadequate for a severe infection. Also, the unconcentrated blood serum at first used was bulky and difficult to administer. Sudden deaths from serum shock and the almost constant occurrence of the mysterious new serum sickness alarmed physicians. It was claimed that the new serum had a serious effect on the heart and that all complications were more common after its use (the latter was really true in a certain sense because more patients lived to have complications). Even to the present day it is common to blame all sorts of troubles on the use of serum, and many of the modern cults bitterly oppose it. However, the newer methods of concentration and refinement have removed most of the objections, and earlier and larger doses have steadily increased its efficacy, so that now the experienced physician no longer fears the disease, if only he sees the case in time before irreparable injury has been done.

So we come to the final period of prevention. Isolation and quarantine proved a failure in controlling the disease, but modern methods of immunisation promise to be more effec-

tive. It was soon found that while the use of antitoxin reduced the mortality of diphtheria to one-third or a quarter of its previous extent, the morbidity remained the same, *i.e.*, there were as many cases of diphtheria as ever, though fewer of them died. This turned attention to the various means of producing immunity. The induction of passive immunity by the use of small doses of antitoxin was introduced soon after the great discovery of the serum. Although this procedure undoubtedly saves many contacts, the immunity so induced is too brief to be of any great assistance in stamping out the disease. The introduction of the skin test for immunity by Bela Schick of Vienna made possible immunisation on a large scale. The possibility of inducing a lasting active immunity by the use of a toxin-antitoxin mixture, first suggested by Theobald Smith in 1907, was applied clinically by von Behring in 1913, and widely adopted in America. Later the use of toxoid or anatoxin, *i.e.*, toxin treated with formol, came into use.

To sum up the whole question, our knowledge of diphtheria has been of gradual growth, marked by many masterpieces of work by many men in many countries, the outstanding publications being those of Bretonneau, of Löffler, Roux, Joseph O'Dwyer, and of Emil von Behring. As a result of the work of all these men and of a host of others this terrible epidemic disease has been largely controlled. The estimate that 7,000 lives a year are saved in New York City from the improved death rate gives an idea of what has been accomplished.

Diphtheria has no longer any license for existing in any civilised community and undoubtedly will soon cease to be an important cause of death. Scarlet fever and other diseases promise to follow in its wake, and there is a good prospect that many of us will live to see isolation hospitals for contagious diseases closed for good and that branch of medical service a thing of the past.

The Development, Management and Care of the Normal Child

By S. J. USHER, M.D., Assistant in Paediatrics, Montreal General Hospital, Montreal

At first sight this subject seems to have very little to do with the nursing of sick infants and children. To know how to handle the abnormal or sick child, one has to know something about the development, management and care of the normal healthy child. Before I discuss the mental growth and development of the child it might be wise to say a few words about the nervous system. There are, first, the sense organs which receive tactile, painful, gustatory, visual, auditory, olfactory and articular impressions; second, the sensory nerves which carry these impressions to the spinal cord, where nerve cells receive and transmit the impulses or messages along motor nerves to muscles or glands. In addition, there is also the brain which supervises the work of the subordinates and which can originate movements that lead to action. It interprets the various sensory stimuli into sensations of touch, pain, taste, sight, hearing, smell, position in space, etc. It was first suggested over a hundred years ago that certain parts of the brain are especially concerned with certain functions. Reflex acts, like those of blinking of the eyelids, sneezing, opening of the mouth in babies at the sight of food, occur as the result of sensory stimuli received through sensory nerves by the cell stations in the spinal cord which reflect these stimuli along motor nerves, without the intervention of the brain. The brain is relatively very large at birth. This accounts for the comparatively large size of the infant's head. The brain grows most rapidly during the first eight or nine months. In idiots and imbeciles the brain is smooth and

small and the skull is consequently small. However, the large size of the head does not necessarily mean great cerebral development; it may be due to rickets or may even be associated with imbecility due to hydrocephalus, that is, water on the brain. At birth the baby's first movements are automatic and reflex in character, that is, its spinal cord is functioning and not its brain. It can cry and suck and it also has a very powerful grasp. This grasp gradually weakens as the baby gets older. Within a few weeks the baby shows some sign of pleasure when a brightly coloured object or light is shown to it. It also shows evidence of memory so that when held in the position usually assumed in feeding it makes movements with its mouth expressive of the desire to be fed. By the end of the third month it can generally recognise its mother. It will wink if a finger is brought close to its eyes. At four months it can hold its head erect. It can do some purposeful act, such as looking for an object that is shown to it. At six or seven months the baby can sit up erect when supported. It can reach an object, can laugh and can play with a rattle. Teething begins at about this time. At nine months it can sit up unsupported. At ten to twelve months it can stand up with support. At twelve to fifteen months it begins to walk and to utter some words. This is a very bald summary of the baby's rapid development during the first year. Arnold Gesell's book on *Infancy and Human Growth* will give you a better idea of the relative differences at the various monthly levels.

While considerable variation may occur in perfectly healthy children, great delay in the development of these acts is due to some physical or

mental cause such as rickets, general malnutrition, paralysis or mental deficiency. Hence, by noticing the age at which an infant acquires the ability to perform certain acts, it is possible to estimate to some extent the degree of his muscular and mental development. If speech is not developed by the time the child is three years old, mental deficiency may be suspected—provided that hearing is not at fault, or the child is not suffering from debility due to some prolonged illness. The old saying, "*Mens sana in corpore sano*," a sane mind in a healthy body, is generally true. It has been found that mentally backward children suffer half as much again from malnutrition and naso-pharyngeal obstruction and three times as much from defective hearing as normal children.

The development of the various senses takes place rapidly. The senses of taste and smell and touch are probably well developed at birth. For the first few days hearing is almost entirely absent. It rapidly improves and soon becomes very acute. Vision is very feeble at birth because the visual centre in the brain is not yet fully developed, and before six weeks the baby is said not to be able to focus its eyes. It begins to recognise objects after the third month.

There are characteristic sex differences. In addition to the obvious anatomical and physiological differences which are primarily associated with the function of reproduction, the sexes differ in the following respects: (1) Metabolic—The metabolic rate is on the average somewhat lower in the female than in the male. A high metabolic rate implies a great expenditure of energy; a low rate means a great storage of energy. Hence man uses up more, and woman stores more energy out of the food they take. (2) Endocrine—The internal secretion of the ovary produces the secondary female characters, that of the testes the secondary male characters, including the

break in the voice. Up to the age of ten years the annual gain in weight is nearly the same for both sexes, boys being on the average a pound or a pound and a half heavier than girls. During the eleventh, twelfth and thirteenth years, girls gain more rapidly than boys and pass them in weight. The thirteenth is usually the year of greatest increase. Boys begin to gain rapidly in weight during the fourteenth year and soon pass the girls. With them the sixteenth is usually the year of greatest increase. With both sexes there is seen as a rule a slowing up of growth before the rapid increase of puberty begins.

To be able to manage children properly it is important to know something about the child's emotions and the dynamic urges that underlie a child's conduct. The most important emotions in early childhood are those of fear, anger and love, as each of these plays its part in the formation of character. Children are instinctively afraid of the dark, of strangers and loud noises. Such fears gradually disappear as the child grows older and is in a position to realise that the danger is only imaginary, but he can be helped to overcome it by explanation and by a demonstration of the absence of fear on the part of his parent or nurse. The child's vivid imagination is also a source of fear. Hence great care must be taken in the selection of the kind of story told to a child. The policeman or the doctor should not be used as a sort of bogeyman to frighten a child. Anger is the result of some annoyance such as physical discomfort, fear or deprivation. This emotion is accompanied by the instincts to scream and strike. Such outbursts of temper should not be encountered by loss of temper on the part of the nurse, but should be treated with tact and sympathy. He should be left alone for the time being, and when the fit of temper has passed off, should be made to realise that not only was there no real cause for such an exhi-

bition but that he gains nothing by that kind of conduct. Each emotion requires an outlet. Fear, for instance, will find its outlet in a fit of crying, which forms a safety-valve for the pent-up nervous tension. This should, therefore, not be immediately checked or repressed, otherwise the delicate nervous system might suffer considerable damage. The proper way of dealing with it is to soothe the child and try to divert its thoughts into other channels and later induce it to tell about the incident. Thus the child will feel that he can always turn to you when in trouble. In addition to these emotions I have described there are, as I have mentioned, dynamic urges underlying a child's conduct. These are of especial interest to anyone looking after children. There is love of affection—every child seeks affection. There is also love of attention—every baby and child demands it and wishes to be the centre of interest. Finally there is the love of power. Every child has a desire to be master. Every normal child wants these things. He works for them and as far as he can be said to plan, he plans his life so as to get them. If he doesn't get them in reality, he builds up a life of fantasy and so satisfies his desires. A normal amount of each of these is due to every child, but they are perfectly willing to take much more than their due if given the chance.

Another great determiner to a child's character and a great aid in the management of children is suggestibility. The child from birth on is highly suggestible. This applies especially to the pre-adolescent or early adolescent years. A child will accept our estimate of him. If we assure him he is nervous he can develop all the symptoms. All our suggestions should be positive ones, that is, we must say what we want him to believe. For example, we may tell him that he is perfectly healthy and that we are surprised to see him

behaving this way. The child must be taught that he will only get our affection and attention as a reward for his good conduct. Children are very imaginative and imitative. Their vivid imagination unconsciously makes them tell untruths. Their imitativeness makes it very necessary not only to isolate them from other children suffering from certain functional diseases such as stammering, habit spasm, chorea, etc., but also that they should be placed in surroundings with right influences. Further, it is his imitativeness and lack of critical faculty that renders the child so amenable to suggestion. As the child grows and begins to sit up or walk his activity grows, and fussy and impatient mothers or nurses are apt to order the very active child to sit still or not to do this, that, or the other thing. Such interference with the child's normal activity, especially when he is engaged upon some new task which he is trying to learn and when his whole nervous system is in a state of high tension, is apt to have the same effect upon it as trying to keep the steam in a kettle by stopping the spout. A nervous explosion may result and the child's nervous mechanism may suffer considerable damage. The nurse or parent should be sparing in the use of "Don't's."

The ideal training centre for the pre-school child is the nursery school. Although already a part of the English public school system it is only as yet largely experimental on this side of the water. The nursery school takes children from eighteen months or two years upward to kindergarten age, and gives them complete training in social and health habits. In its proper form it gets the babies early in the morning, provides all their meals, teaching them by group participation how and what to eat, supervises their play—much of it outdoors—and their relationships to one another, settles them in their cribs for the after-dinner nap, and restores

them to their homes at bedtime. The school takes a group of little folk and teaches them by actual experience how to be social animals and how to care for themselves. Another method of teaching children up to two or three years is by the Montessori system. This is divided into three parts. The first part is motor education, which consists in giving order and direction to the child's uncoordinated movements, leading him to do those actions which he is aiming to do. These muscular movements have reference to walking, handling objects, personal care such as dressing and undressing, domestic work, gardening, rhythmic movements, etc. Thus for the purpose of dressing and undressing, there is a collection of frames to which are attached pieces of stuff which can be buttoned, hooked or tied together. The teacher performs on these frames the various necessary movements involved in fastening or unfastening our clothing, one act at a time and very slowly in front of the child. The child is then given the frame and is encouraged to repeat these actions for himself. In this way they soon learn to dress and undress themselves. Similar methods are adopted for teaching other movements. The second part is sensory education. The child is given rows of cylinders differing either in height only, or in diameter only, or both in height and diameter. The exercise consists in placing them in the appropriate hollows in a block of wood. By repeated trial and error he soon learns to fit all the cylinders into their appropriate holes. In this way he learns to appreciate differences in dimension. Other exercises have been devised to train the sense of touch, temperature, as well as the appreciation of colour. The third part is language and writing education. The main principle of the Montessori system is that of auto-education, in other words, education without guidance or interference by the teacher. The teacher mainly

shows how a certain thing is to be done and leaves it for the child's innate instincts of curiosity and imitation to repeat the exercise and learn from his own mistakes. The system is a very attractive one but is only applicable to children who are mentally perfectly normal.

The formation of correct habits from birth onward, is of great importance in the proper management of children. The constant repetition of any act results in the formation of a habit. This is particularly the case in children and the younger the child the more easily is the habit acquired. The nervous system of the child is still plastic, so that a very few repetitions of the act will be sufficient to leave a lasting impression. It must be remembered that it is as easy to train a child into good habits as into bad ones, and that it is as difficult to get out of a bad habit as of a good one. Hence, the training of a child into good habits should begin at the earliest possible moment, immediately after birth. The first habits to be taught at this early age are regularity of feeding and of evacuation of the bowels. It is of the greatest importance that a mother should be taught not to lift the baby every time it cries and nurse it or put a bottle in its mouth. As the child grows older, the food habits must be enlarged in scope so that the child is accustomed to eat any food that is offered to it without coaxing. It must also be made to acquire habits of kindness, unselfishness, restraint and self-control, self-reliance, accurate observation, personal cleanliness, punctuality, truthfulness and courtesy. Good and bad habits can also be acquired by associating any particular behaviour with some particular conditioning stimulus. Thus, by holding out a baby over a receptacle at times when a movement of the bowels is found to be taking place naturally, a conditioned reflex is in time established between the sight of the receptacle and the reflex

act of defæcation, thus ensuring clean habits even in very young babies. Similarly, allowing the baby always to sleep in a dark room will render it unable to fall asleep in a lighted room, but by varying the illumination of the nursery from time to time, the baby can be trained to go to sleep under different conditions of lighting. If the same flavouring agent is always given to a child to conceal the taste of a nasty drug an association will be established between the drug and that flavouring agent so that a dislike or even a feeling of disgust will be established in the child for that particular flavour. Such examples can be multiplied almost indefinitely and their value in child training will be easily appreciated. The child should be trained along an ascending scale of acts of endurance and self-denial, and deeds of kindness which involve subordination of self to the interest and benefit of others. He must be trained to withstand temptation, even if left alone with some chocolate, jam or other dainty of which he is particularly fond, and he must learn to give up a favourite toy to another child who is in greater need of it than he. In this way self-control will gradually be acquired as a habit. The teaching of such good habits will thus lay an excellent foundation for the moral development of the child, which after all is as important as his proper physical development.

It also is necessary for you to have a proper understanding of the child's play requirements. The child needs first and foremost his own room and his own play-yard. They give him

physical security from the mishaps that may overtake him in the adult room and they liberate him from the presence of forbidden things. He becomes an independent social unit until such time as he is old enough to be interested in the garden and house of the family. During early childhood, the little boy or girl, whether rich or poor, loves to play with sand. The children of the well-to-do will build sand castles at the seaside or in their gardens, those of the poorer classes will make mud pies whenever they get the opportunity. Other games at about the same age or a little later are those of adventure in which secrecy forms a part. They will play at hiding, pirates, big game hunting, etc. Later on, games of ceremonial and of construction occupy the child's mind. The boy will play with mechanical toys, build houses, boats and other structures, whilst the little girl will play with her dolls. At a later stage still, the child shows an interest in organised games such as marbles, cricket, football, etc. It is necessary to recognise these various stages if we want to be able to supervise a child's play intelligently. Another thing we must recognise is the child's natural curiosity. This trait is merely a natural appetite after knowledge which should within reasonable limits be encouraged. The child who takes his engine to pieces to see how it works is simply carrying out a natural and perfectly praiseworthy impulse. All toys given to children should be such as to enable them to satisfy their legitimate curiosity without any injury to themselves or undue expense to their parents.

A Day with the Clinic's Visiting Nurse

By BLANCHE EMERSON, Edmonton, Alberta

The nurse stirred wearily on her pillow, for the day was returning, bringing with it the usual petty round of cares and commonplace tasks.

Petty indeed, they seemed at this particular hour of the morning to the nurse who knew she must rise and go visiting. Well she knew that the same questions asked hundreds of times before would be asked and answered hundreds of times again. True, as someone has pointed out, the same person hadn't been told the same thing a hundred times but in the rush and hurry of the day, it is apt to seem that way to the busy nurse.

Before finally tearing herself away from her comfortable bed she let her vagrant fancies carry her where they would, and this morning they played a little game called in her childhood, "Let's pretend." Let's pretend that I don't have to be patient, kind and tactful to the families I have to visit today, and can just say to them what I think.

"No, Mrs. Jones, it is not a good plan to keep the baby awake until ten o'clock at night so that she will sleep later in the morning. Mornings were made to get up in, not to sleep through."

"And Mrs. Brown, how many times have I to tell you that castor oil is never given to cure constipation."

"You — Mrs. Smith — know well enough that you are only trying to get out of giving baby its daily bath, for such babies need baths even more than well ones."

"No, Mrs. Hauptheiser — sauerkraut, liver, sausage and coffee have never yet been found on the diet list of any young child."

"You wonder, Mrs. Ching Lee, why your baby is so restless—Well, let me tell you, she wasn't sent for you to use her as a toy to amuse your Chinese friends with. She has

a crib, why not let her stay in it."

Resolved to smile—if possible—at Mrs. Slevensby and say, "So you don't approve of our clinic methods? Oh, well you came of your own accord, we didn't send for you."

Laughing to herself as the thought of the replies she might receive in return for information imparted in this way, she was now thoroughly awake and ready for anything the day might bring.

So she went visiting. . . .

Her first call was on a Ukrainian family: A man opened the door who could not speak English. He called, and in they came: men, women and children to find out what was going on. One of them, a man, acted as interpreter — questions were asked and answered on both sides, and considerable advice given, it even being suggested to them that they should learn to speak English. After examining the baby and other children of pre-school age, there was much smiling and nodding of heads, and the nurse passed on to the next family.

At this home, conditions were not all that could be desired. The father had been out of work for some time, and too proud to ask for help. The family had struggled on until they were almost at the end of their resources. A heater with one lid was their only means of cooking a meal. As tactfully as possible the nurse mentioned that she had some clothing that would fit Mary and Johnny, and enquired if she might bring it around. The mother would not accept for herself, but did for her children. A kindly group of women provided a cook stove and work was secured for the father, so the burden was lightened a little.

In the next home she was met by a cheerful little Cockney woman who announced: "E's 'ome, that's wot 'ee his, nurse, and don't be 'ard on

'im, for hit wasn't 'is fault, it was false hevidence and henemies that put 'im where 'ee was." Her prodigal had returned.

Then came a visit to a young mother who was caring for her first baby. Much time was spent here. The little mother said she was far away from her own mother, and a stranger in the city, and so the clinic with its doctor and nurses filled a large place in her life during these anxious days.

There was the negro widow, who had brought three nameless waifs into the world during her widowhood, the last two being twins, who when asked how she was getting along began to weep, and as the big tears dropped down over her dusky face, exclaimed: "Ah is endeavouring to lead an upright life. Ah reads ma Bible to mah chillen every day for I does want them to be good." The kinky-haired twins looked up from the box where they were playing, and the other little pickaninnies gazed at their mother evidently wondering what it was all about, and then went quietly on with their play.

Then there was the little foreign widow, whose husband had been dead only a short time, who happily announced that she was being married again Saturday morning at the Holy Maternity Church on the South Side.

The little French-Canadian baby, fourteen months old, who couldn't walk, but who could speak both Eng-

lish and French, who looked up at the nurse and smiled, and in the most approved fashion said, "Oh yeah."

The woman who felt so sorry for the next door neighbour because she had just had an "amateur" baby, and it was so wee and needed so much attention. Would the nurse mind going in to see her.

The mother who had lately lost her child and couldn't understand "why?"

The expectant mother, so full of fears and age-old superstitions, who had not yet seen a doctor, for whom arrangements must be made.

The jolly Hungarian, so many of whom lived in the same block, who greeted the nurse joyously and noisily, who spoke to her of the vine-clad hills of Hungary, of the beauties of Budapest, and of their present joys and sorrows.

The little pre-school girl who came running eagerly to meet her to tell her she was drinking milk at every meal now, and eating spinach and carrots, just as the doctor said.

The chubby-faced boy, who shyly said, "I know you; you're Clinic."

So the day wore on. Many were the stories told: sad stories, gay stories, stories full of tragedy, or pathos. Yes—and many were the questions answered, but somehow the nurse didn't find them irritating now. She had entered into their joys and sorrows, and had gained their viewpoint.

MY CREED

I believe in Canada.

I love her as my home.

I honour her institutions.

I rejoice in the abundance of her resources.

I glory in the record of her achievements.

I have unbounded confidence in the ability of her people to excel in whatsoever they undertake.

I cherish exalted ideals of her destiny as a leader among world nations.

To her I pledge my loyalty.

To the promotion of her best interests I pledge my support.

To her products I pledge my patronage.

And to the cause of her producers I pledge my devotion.

By the HON. HENRY H. STEVENS,
Minister of Trade and Commerce.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

The Case Study Method of Ward Teaching

By EUGENIE M. STUART, Toronto General Hospital, Toronto, Ont.

The principles underlying the present Case Study Method of teaching are not modern. From nursing history we find that Florence Nightingale, in the Nightingale School in St. Thomas's Hospital, London, England, encouraged the students in a method of study similar to our present day Case Study Method. The first we hear of the case study is not in nursing, however, but in law. In 1871 Dean Langdell of the Harvard Law School introduced the case study with a definite purpose—that of seeing the entire study of law built on the study of separate cases. From that time till the present the Case Study Method has been used in various types of education. However, only recently has it become utilised to any great extent as a means of ward teaching in schools of nursing.

The main objects of the case study are:

- (a) To have the student gain an understanding of the patient as a whole, to see the patient as still a member of his family and the community.
- (b) To help the student seek information about her patient in an organised form.
- (c) To develop powers of observation in the student.
- (d) To emphasize the importance of understanding the treatment applied for the patient's recovery.

The time in the nurse's training and the number of case studies written are much debated points. It is felt that any time during the student's training is suitable as long as she is actually nursing the patient.

The question arises—should preliminary students write case studies? For the past two years our students have been writing one study while engaged in the nursing of two patients at the termination of their preliminary term. At this early period in their training this method of ward instruction teaches them to help themselves and also how to study from text books. The number of case studies to be made is an important point and one in which the time factor of both student and supervisor plays a great part. In general it may be said that it is much better to have the students make one complete case study in any service, one which really allows for thought, study and observation, than to have a number of superficial reports made which tend to become routine. At least one study in each of the medical, surgical, dietary, out patients' and obstetrical departments is advised and more if time permits.

My knowledge of the method by which the Case Study Method is used in various schools is rather limited and therefore the method of procedure in Toronto General Hospital only will be outlined.

The student's experience in each of the surgical and medical divisions is three months. When the student is assigned to the department the usual informal conference is held on the ward with the head nurse: duties outlined along with ward routine and explanation of special equipment. Some time during the first week a formal, individual conference is held with the supervisor of the department in her office. The time taken for this conference varies with circumstances, such as the seniority of

the student, her previous experience, her adaptability, but approximately one hour is spent. During this conference a general outline of the types of patients on each of the medical or surgical wards is sketched. To the student is emphasized the double responsibility: (a) to the hospital for the care of the patient; (b) to herself for her own education. The advantages of knowing thoroughly each patient are pointed out, this by a synopsis of the patient including his date of admission, condition on admission and progress, occupation, social background, and problems, provisional diagnosis, treatment, nursing care, health instruction for each patient and preventive measures applicable to the individual patient. Special emphasis is laid upon the fact that the patient is still a member of his own family with social needs and relationships. The checking up of all material with reference books, magazines and by discussion is stressed. At the end of this conference a record is made of the student's attitude and insight into problems. A small note book is provided in which the nurse may make her summaries.

When the student begins her second month in this division a second conference is held between the student and supervisor. A complete explanation is made of the case study and note is made of the progress of the student during the first month. The greater number of schools using the case study have a printed form which serves as a guide for the student. The headings in this form are suggestive and act as a guide only as to what information would be helpful in understanding the needs of the patient. They are meant to stimulate and direct keen observation and to teach the students to interpret their observations. The student is advised to select the patient whom she wishes to study and submit her choice to the head nurse who will discuss with her the wisdom of her choice, and determine whether

or not the student needs help and guidance before continuing with it.

The sources of information should be merely outlined. The student should be encouraged to find these for herself. The main source of information is the patient. The student must be impressed with the importance of the development of tact in talking to her patients. The doctor's clinical chart is a valuable source of information, but as the case study is strictly a nursing study the chart must be used with care and understanding. The head nurse is the individual who can give the student more help in gaining material than any other person. She has seen the patient daily since admission, noted his progress and the results of treatment. The social worker may frequently be called upon and possess the knowledge which emphasizes the relationship between the home conditions and responsibilities, and the patient in the hospital. Home visits with the social service worker are advisable but not always possible. X-ray films often show the abnormal condition existing, possibly correcting some misconstrued idea the student has already gained. The dietitian in many cases can give valuable help.

The student is given two weeks in which to write her case study. At the end of this time it is handed in to the head nurse who reviews it with the student and then it is given to the supervisor. The supervisor then arranges for a third formal conference with the student in the supervisor's office. An ideal situation would be to have the head nurse attend this conference also. At this time the study is reviewed by the supervisor and any corrections made or false impressions rectified. Any criticism is as far as possible constructive rather than destructive and the study is graded. A permanent record is kept of each student's interviews and results with grade of study.

Case Studies form excellent material for teaching and discussion in formal classes of nursing, dietotherapy and materia medica. By this means material is collected, not only in specific cases and about nursing in general but knowledge is organised in a form which permits the checking of work to note progress made in content and method, to compare facts presented by the study of a great many cases of the same class and of different classes and to select facts common to all cases of the same class.

Our statistics show that the average time spent on one case study varies from nine to twelve hours.

The Case Study Method of Ward Teaching is still so very young that it is difficult to predict the outcome.

The majority of schools which have already adopted the method feel it is a great advance and there seems to be a growing interest and appreciation of the use and value of case studies.

In resumé, I might say the values of this method of teaching are:

(1) A better nursing through a better understanding of the patient.

(2) A better knowledge of how to study by the student.

(3) A wider knowledge of available material.

(4) A better knowledge of the method of applying material gained in nursing one patient to the nursing of other patients.

(5) It correlates theory with practice.

Educational Problems

By Dr. G. CLOWES VanWART, Fredericton, N.B.

Permit me in the first place to express my appreciation for the honour that has been conferred on me by the New Brunswick Association of Registered Nurses. There is no manifestation of kindness and approval which could have pleased me more.

The subject as on our programme is "Educational Problems." We have our graduate nurses who have completed successfully three years' training from a standardised hospital, many of whom have passed the requirements necessary to become a registered nurse in New Brunswick.

The age of admission and the applicant's preliminary education vary in New Brunswick according to the hospital. After becoming a graduate nurse many of our nurses then take a post-graduate course at a different hospital or college to specialise in one particular phase of nursing.

We still have with us the practical nurse and the midwife who fill a distinct public need. The majority of these have not had the advantage of

much special training. The outline which I am about to suggest is for a uniform and more highly developed training. This is an educational problem in itself.

The aim of a school of nursing is to develop a type of professional education for the student nurse and thus to contribute better service to the field of nursing.

At present the supply of nurses is greater than the demand and the greatest handicap of many a nurse is her lack of preliminary education.

I would suggest that the entrance requirements of the student nurse to the school of nursing should be the same as that of a full-course student entering the first year of a university for a degree. Also, that the applicant must be unmarried and at least eighteen years of age and be able to show evidence of good character as well as physical and mental fitness.

The course of training must follow a definite educational plan. One must always remember that the patient is the first consideration and that the education and training of the nurse is to lead to efficiency in his care.

There would be two distinct courses: The first, or Course I, which would cover a professional curriculum of eight months at a university and three years at a standardised school of nursing. This course would lead to a Diploma in Nursing.

The second, or Course II, which would cover approximately a professional curriculum of two years and four months at a university and three years at a standardised hospital. This course would lead to a Bachelor of Science Degree in Nursing from the university and a Diploma in Nursing from the school of nursing.

The tuition fee at the university should be moderate and rewards for efficiency in studies be provided by scholarships.

The synopsis of Course I would be as follows: All instruction in the first year would be given at the university. The student would receive a preparation in the basic sciences upon which to build her clinical experience so that she would be more intelligent in giving nursing care to her patients.

The subjects taught while fitting into the regular freshman year at the university would be selected for their value as a professional preparation. Following a vacation of four weeks the student would enter the school of nursing for a course of eight weeks, in which she would study elementary nursing practice on the wards. This would be done before the first fall term in the school of nursing.

During her first year in the school of nursing, instruction would be continued in nursing in medical and surgical diseases by means of classes and conferences. An average of 18 hours a week should be spent acquiring skill through practice in the care of patients.

The second and third years in the school of nursing would be devoted to the specialities in nursing and to the practice in the various specialised departments in the hospital and public health field.

The synopsis of Course II would be as follows: The first two years or pre-nursing years would be spent at the university, where instruction would be given in the general cultural subjects. This would give the student the opportunity to share in the social life of the college as well.

On the completion of the two pre-nursing years at the university and after a vacation of four weeks on the completion of this second year, the student would enter the school of nursing for a summer course of eight weeks and begin nursing practice on the wards. Then she would enter the first fall term at the school of nursing. The course of study would deal with the causes, prevention and nursing care of all varieties of disease.

The last four months of the fifth year would be spent in the university completing the required work for the university degree and making a study in the particular field in which the student is most gifted.

Dietetic experience would be gained in the hospital dietary department, while operating room procedure and surgical technique would be learned in the general operating rooms. Through the department of obstetrics and obstetric clinic the student would be given a thorough course in antepartum and post-partum nursing. The lecturers to the student nurses should be full-time teachers.

After completing this training the nurse would be ready for the nursing care of the sick, the teaching of public health in the hospital and homes of the community or teaching administration positions in schools of nursing.

While in Peiping, China, I had the pleasant experience of visiting a well-organised hospital. A course quite similar to this is followed by the school of nursing connected with the Peiping Union Medical College there.

If this system is workable in the Far East, why not in New Brunswick? The principles of nursing are the same throughout the civilised world. It is the spoken language and customs

which are so different in the East and West. We both have our well-organised hospitals and universities.

Improvement in our present system is desirable and any constructive suggestion should receive earnest attention. A satisfactory solution might be affected by a conference of representatives from the New Brunswick Association of Registered Nurses, the Faculty of the University and those responsible for the curriculum of the schools of nursing. In this way much could be accomplished in the exchange of ideas and the best methods of their application.

In this brief paper I have omitted

purposely the details and have given only a suggestive outline for a more thorough and efficient course of training for nurses.

An affiliation between training schools of nursing and a Canadian National Registration Nurses Examination Board would enable the graduate nurse to become registered throughout Canada.

In conclusion, I may say, that we must advance with the signs of the time, as in the past our graduate nurses from New Brunswick have brought much honour to their training schools from both the East and West.

Criticism of Standard Curriculum as Outlined in The Canadian Nurse

(By Request)

My first thought is the great difficulty in planning any standard course of study for Canadian Schools of Nursing where there is such wide variance in the number of beds in accredited schools (50-1000), and in the educational requirements in different provinces for students entering these schools.

Would it not be wise to have a uniform educational requirement for admission obtained prior to planning a curriculum, or plan for it at the same time as for the course of studies?

With such great differences of required educational standing as exist now in many of the provinces, it is almost impossible, as I see it, to carry on any standard course in schools of nursing. Grade XII (junior matriculation or high school graduation) as required admission standard would certainly simplify present conditions and remove many existing difficulties.

The weak point in any standard curriculum is that unless a well-equipped instructor is available there

is danger of camouflage. Who has not known the difference between the printed prospectus and the actual teaching in some schools of nursing?

In the curriculum presented I consider that too much time is planned for class work in the junior year. An allowance of three hours a day is practically impossible in a busy hospital. This three hours a day class work works out to be really six hours a day away from wards (two hours recreation, three hours class and one hour for meals). I would suggest a longer preliminary period, one of five months. Admitting students in September and February, each class would get through with a larger number of class-periods and be ready for the wards. These students are of the least value to the hospital in these first months, and are fresh for study.

If we investigate the high school curriculum we will find chemistry, personal hygiene, health and physical education, home economics (foods) and other subjects closely allied to those we

require in schools of nursing, and which can be better taught in high school, where laboratory and other equipment is available, rather than in the hospital where, except in the largest ones, these exist only in the sketchiest form, if at all.

All these subjects may not be included in the programme of the high school studies in all the provinces; effort on the part of those interested in nursing education will prove that little difficulty is encountered in obtaining a sympathetic hearing, but rather that assistance is given. With vocational directors in so many schools the path is much easier. We do not need to ask for a special course to be provided, but with the co-operation of the Provincial Board of Education and two or three principals, much can be done by proper selection from the curriculum already existing in the high school systems.

Some provision for mental hygiene and more psychology should certainly be included. Probably affiliation with mental hospitals will solve that prob-

lem. Psychology carefully taught seems to me to be one of the most important subjects for the improvement of the nurse's technique and knowledge of the patient, who is never quite normal.

I query the value of massage being included in standard curriculum. In the smaller schools, at least, it is practically impossible to obtain a first-rate fully qualified masseuse to give such a course, and there is always the danger that the physician will feel justified in ordering a "massage" and more harm than good would be the result.

Our great aim, or so it appears to me, is to bring continuous pressure on Provincial Departments of Education to provide a special high school course leading to matriculation; and till then to utilize the subjects already at hand; and in addition to getting better teaching in subjects required by nurses, we also save time in the school of nursing, which would allow re-arrangement of the curriculum to the advantage of student and hospital.—H.R.

The Grading Committee Plans

The Committee on the Grading of Nursing Schools (United States) held its semi-annual meeting on November 20 and 21, 1931. The meeting was perhaps the most interesting and constructive of any which have occurred so far in a long series of successful meetings. Briefly summarised, the chief decisions which the committee reached are as follows:

1. The committee plans to continue its work for two more years if funds can be secured for that purpose. It starts the new year with enough money to carry the work well into the spring, and there seem reasonable prospects of securing additional gifts from a number of different sources. The committee believes

that to stop the work at this time would leave several important projects unfinished.

2. The committee has agreed to make a second grading. This will make it possible for schools to discover how much progress they have made since the first grading two years ago. This work will start early in January. All schools listed on the Accredited List, recently published by the National League of Nursing Education, will be invited to take part. Those which accept will be sent monthly installments of report blanks, in very simple form, so that no undue amount of work will be called for at any one time. The study will probably cover the greater part of 1932,

and reports will be sent back to the schools which take part as promptly as possible after the tabulations are completed.

The committee has agreed that no white list or black list based on this second grading shall be published at this time. It is, however, the present hope of the committee that, when the study is through, it may be possible to compile the results in a series of educational comparisons which may be made available to individuals who ask for specific information. In other words, there will be no published list showing how one school compares with another. Neither will there be any single mark or rating. Schools will, however, be compared on a fairly large series of different items; and it is the hope of the committee that the material will prove sufficiently valid so that information concerning where a given school stands on any particular comparison may be made available to inquirers. It is the belief of the committee that the time has come for some information based on gradings to be made available to prospective students and other interested persons.

Schools taking part in the study should, therefore, understand that while no general publicity will be given to the results for individual schools, nevertheless the material will probably not be considered confidential in the same sense as was the material of the first grading. It is understood that some few schools will hesitate to take part in a grading made on this basis, but it is believed that the better schools in the country will be glad to avail themselves of the opportunity.

3. The Committee on the Grading of Nursing Schools is already attempting to formulate what may be thought of as minimum standards, which every school of nursing must meet if it is to call itself a school. These standards will be placed so low that there can be little excuse for any school not to meet all of them. Due consideration will be given to the fact

that many schools are financially handicapped and most work slowly towards improvement. It is felt, however, that the time has come when there should be some general agreement as to what may properly be considered a true school of nursing.

4. Towards the end of 1933 the committee plans to publish a final report, signed by the full membership of the committee. Work on this project is already under way. The report will include, first, discussion of the problems concerning nursing education as the Grading Committee has seen them, and, second, whatever recommendations the committee feels qualified to make, leading towards the solution of these problems.

5. The committee has now in preparation and hopes to place in published form by the end of 1933, a practical handbook of the methods of grading which have been evolved through committee experience. Such a handbook could be used as a tool for grading or accrediting by local or national organisations. It would be subject to revision from time to time, and could be adapted not only to the questionnaire method, but to the necessities of studies made through personal field inspection.

By carrying through these various projects, within the next two years, the committee believes that it will have met, in so far as is within its power, the chief needs of the nursing and allied professions.

The programme as adopted is a heavy one. The committee feels fortunate in having secured for a limited period the services of Miss Ethel Johns, R.N., who will make the necessary field contacts and will take an active part in preparing material for the final committee report. Miss Johns has just completed an important service of a somewhat similar kind in connection with the School of Nursing, which, under the direction of Miss Anna D. Wolf, is now being organised in connection with the New York Hospital-Cornell Medical College project.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,

Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

The Conception of Cancer One Hundred Years Ago

By N. E. BERRY, M.D., Professor of Urology, Queen's University, Kingston, Ont.

Cancer presents the most formidable challenge which confronts the medical profession today. Possibly no subject attracts more research and certainly he who brings forth the solution will be the greatest benefactor of the age.

It is of interest to examine the writings from the School of Medicine in Paris at the beginning of the 19th century. They were really in advance of us today because they knew the actual cause of cancer. It was, they said, due to an engorgement and drying up of lymph in the affected part. This became transformed into the virus. How it came about was a bit puzzling but was explained easily by saying that it depended on vital forces. They scoffed at the ancients who thought it was the result of certain deleterious qualities of the bile, a yeast or a coagulating acid. They knew the actual cause and were only waiting for a specific similar to mercury for syphilis. Of course syphilis and gonorrhoea were at this time considered as different manifestations of the same disease and here again they were certain mercury was a complete cure. As a matter of fact cinnabar (mercury-sulphide) had been used for centuries by many Asiatic tribes who burned the ore and sniffed the fumes to cure themselves of syphilis. Unfortunately here again we

are not so efficient, we cannot cure syphilis now by mercury alone.

They divided the contributing causes into external and internal. In the first group they recognised the deleterious effects of various forms of prolonged irritation and their observations were accurate. Many writers call attention to the habit of repeated application of caustic to warts on the face as being a prolific cause of cancer. As to the second group or internal causes, their explanations were more fantastic. Chief among these causes is inflammation when it ends in induration and the cessation of an habitual discharge; such as from haemorrhoids, or in women, from menstruation. This latter was recognised as the cause of cancer of the breast and of the uterus. But it could also cause cancer elsewhere as a case is recorded of a woman who was attacked with a cancer of the face following a derangement in the menstrual function. It had been thought that this resulted from the blood being carried to the affected part, but that theory was being cast aside, especially since it was admitted cancer could begin in women whose functions were normal. Engorgement of the breast was a common cause of cancer and similarly engorgement of the male glands due to syphilis. It is easy to understand this latter hypothesis

since the two conditions could not possibly have been distinguished with the methods then at their disposal.

Many other factors contributed in certain cases, e.g., a life of sadness, sedentary occupation, long and deep meditation, etc. It was thought that these factors were active through slowing of the circulation. Similarly there were certain subjects of a disposition which favoured the development of cancer, e.g., those of a bilious temperament, melancholy, etc. Even shame might cause cancer to grow rapidly in certain individuals who had previously had a slowly growing tumor.

They were not quite so certain as to the influence of heredity. It was doubtful if a person suffering from established cancer could procreate and, therefore, there seemed little likelihood of this. But there was no doubt as to its being infectious. An instance was cited where a surgeon was attacked with cancer of the mandible after having tasted the virus (which

he found quite sour.) Similarly children had been infected from nursing a breast which was the seat of cancer. Animal inoculation, too, had proven its transmissibility. Here again they were in advance of modern science for we are quite unable to do this now.

Most interesting of all are their speculations as to the actual nature of the virus of cancer. Some regarded it as an alkali, others as an acid, but they had to admit nothing more was known of it than of the other viruses.

Today we know the nature of these other viruses, what they saw through a glass darkly we see face to face: we smile at their hypotheses, most of which we now know are wrong but we really know nothing more as to the actual cause of cancer than was known one hundred years ago. Let us hope that before another fifty years our ideas will be equally ludicrous and that the real cause of cancer will be as familiar to us as the typhoid bacillus is today.

ANNUAL MEETINGS

Manitoba Association of Registered Nurses—Legislative Buildings, Winnipeg, at 3 p.m., January 14, 1932.

Association of Registered Nurses of the Province of Quebec — Central Y.W.C.A. Auditorium, Montreal, January 25 and 26, 1932.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.

MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

A Busy Day on the Tobique

By EDNA GAUNCE ROSS, Riley Brook, New Brunswick.

[That pioneer nursing is not confined to the "younger" section of this country is evidenced by the graphic account of a busy day, rather days and nights, of the public health nurse on the Tobique River, N.B. Mrs. Edna Gaunce Ross, whose headquarters are at Riley Brook, covers a district of about thirty-five miles in length up and down the river. She not only takes care of the bedside work, but does the school nursing in the several schools of the district, infant welfare and tuberculosis work, to say nothing of the thousand and one calls that are listed as "social service." The service here is a continual adventure, and in winter an extremely arduous one, there being no means of transportation except horse and sleigh. Financing of the service is covered by the Department of Health, the parish and the Tobique Salmon Fishing Club, a club of New York sportsmen, many of whom have been glad to call upon the nurse in an emergency, and who through years of association with the farming people of the district have taken a keen interest in the welfare of the community.—H. G. D.]

About the middle of April, having sat up with a boy all night, we decided to take him to the doctor, a distance of twenty-seven miles. At 9 a.m. we were ready to start, with a team and a sleigh which had a tent over it, and the patient on a bed inside.

On passing my home I was called in to answer the telephone. A boy of four years, living about seven miles down the river, had been playing with a dynamite cap, which exploded and tore his hand, leaving the thumb and little finger dangling with broken bones; the other three fingers blown about the room. I told the mother I would get there as soon as possible and we would have to take the child to a hospital.

The school was handy and the teacher a "brick," so she took her first aid kit over and fixed up the hand. I left my first patient to follow, and as my father had our horse

and sleigh ready, away we went as fast as we could, which was not very speedy as the roads were bad. When I got there I re-dressed the hand and telephoned the doctor, resident about twenty miles farther down the river.

The mother was ready and the child wrapped in blankets, who, though having been given an opiate, remained terribly excited and frightened: the wound kept oozing. The mother and I sat in the sleigh and held the child, while a boy drove for us. After driving nine miles we changed to fresh horses and teamster that were ready, but we did not stop to eat, and at 4 p.m. arrived at the doctor's office. I helped him to dress the hand.

The doctor made arrangements by telephone for us to take the child to Grand Falls Hospital, another twenty-eight miles down the river. Assuring us that he would make ar-

rangements with the agent, the doctor advised us to take the fast freight train. We went to the hotel, had supper, and when my other patient from Riley Brook arrived I helped the doctor with him. The station, about two miles below the village, closed early, so away we went and arrived there about 8 p.m.

The man with the horses helped us into the station and departed. I gave the child to the mother and went to the wicket to secure tickets. The doctor had neglected to notify the agent, who said he would have to telephone to Moncton to make reservations, "as it was against the rules and we should have a man with us too." I talked and explained, I was so disappointed. The agent was very kind and sorry. He telegraphed and did the best he could but it seemed hours before he said, "It will be all right." The freight would stop for us. He wanted to help in any way he could, but there was nothing to do but wait so he locked up and went to bed and we were left alone. It was dismal waiting.

When the freight arrived about midnight we went out on the platform but the cars rushed by; we gave up hope of it stopping. I had counted seventy-five cars before it came to a stand still. We got on—the train men were very nice and we arrived at Grand Falls station about 2.30 a.m.

Although there was no snow in Grand Falls, on the road to the hospital there were many drifts two feet deep, and the man the doctor had engaged for us had a carriage. It was only a two mile drive but seemed endless. I held the child on my lap while his mother sat beside me. The driver stood behind and we travelled as fast as the horse could go. I breathed a sigh of relief as we drove up to the hospital door. When the nurse came and helped me in with the child the mother turned and fled down the street, I knew not whither.

We were kindly received and after being made comfortable the doctor came and heard my story, then arranged for me to have breakfast while he had his.

By the time the child was ready for the operation, the mother returned. The doctor talked with her and then sent her for a walk.

The child took ether nicely, and it was found necessary to amputate at the wrist. The operating was all over and cleared away by 9 o'clock, the child in bed and doing fine. So we called it a day! His mother and I stayed with him all day and the following night—it helped to keep him quiet.

The stump healed wonderfully, and today he can use it to tie his own shoestrings or in a scrap, to down a boy older and larger than himself.

SUNSHINE TABLE

Gradual Exposure of Baby's Body	Day															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	NUMBER OF MINUTES															
Hands and Wrists, Feet and Ankle	5	10	15	20	25	30	35	40	45	50	55	60	60	60	60	60
Ankles to Knees		5	10	15	20	25	30	35	40	45	50	55	60	60	60	60
Knees to Hips			5	10	15	20	25	30	35	40	45	50	55	60	60	60
Hips to Chest, front and back				5	10	15	20	25	30	35	40	45	50	55	60	60
Chest to Neck, front and back					5	10	15	20	25	30	35	40	45	50	55	60

This Sunshine Table is published by courtesy of the Manitoba Medical Bulletin, October number. Our nurses may find this Table of value to them in directing mothers in the use of sunshine as a means of preserving good health in their young children, especially during the winter months.

News Notes

NEW BRUNSWICK

SAINT JOHN: A well-attended meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses was held on November 16, when Dr. George F. Skinner gave a much appreciated lecture on Thyroid Glands. Miss E. J. Mitchell, president, was in the chair. Sincere sympathy is extended to Miss Louise Peters on the death of her father.

The Alumnae of Saint John General Hospital met at the Health Centre on December 6, as the Nurses Home was undergoing renovation previous to its reoccupancy by the nurses. During the construction of the new hospital buildings the nurses have resided in the annex for infectious diseases. A letter was received from the Commissioners of the Hospital, who expressed their appreciation and thanks for the Alumnae's gift of five hundred dollars, donated towards the furnishing of free beds in the new buildings. Plans were made for a bridge to be held some time in January.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in December, 1931, were 954, three more than in November, 1931.

APPOINTMENTS

CIVIC HOSPITAL, OTTAWA: Miss Lillian Alkenbrack, 1930, as X-Ray Technician at the Queen Victoria Hospital, North Bay, Ont. Miss E. Gertrude Ferguson, 1930, as Follow-up Supervisor at the Ottawa Civic Hospital. Miss M. L. Lutton, 1928, as Assistant Supervisor in the Out-Patient Department of the Ottawa Civic Hospital. Miss Ruth Fraser 1931, Night Supervisor at the Protestant Infants Hospital, Ottawa. Miss Dorothy F. Gorman, 1930, with the Papineauville Health Unit.

DISTRICT 1

VICTORIA HOSPITAL, LONDON: The annual meeting of the Alumnae Association was held at the Gartshore Residence on December 1, when officers were elected for 1931-1932: Hon. President, Miss Hilda Stuart, Superintendent, Victoria Hospital; President, Miss Mae Jones, Windsor and Ridout St., London; First Vice-President, Miss Christena Gillies, Victoria Hospital; Second Vice-President, Miss Margaret McLaughlin, Victoria Hospital; Treasurer, Miss Mildred Thomas, 28 Hayman Court, London; Secretary, Miss Verna Ardiel, 1000 Lorne Ave., London; Corresponding Secretary, Miss Gladys McDougall, 14 Bellevue Ave., London; Board of Directors, Misses Mallock, M. Walker, Mortimer, Mrs. L. McGugan, Mrs. H. Smith, Mrs. Sterritt; Representatives to "The Canadian Nurse," Miss G. Erskine, Victoria Hospital, Mrs. Seanlon, 769 Quebec St.

DISTRICT 2

BRANTFORD: A meeting of the Executive Committee, District No. 2, R.N.A.O., was held at the Victorian Order of Nurses headquarters, Brantford, on November 27. The following attended: Misses A. E. Bingham, A. S. Weber, Kitchener; Miss M. Davison, Woodstock; Miss M. E. Cade, Tillsonburg; Miss H. Booth, Simcoe; Miss S. M. Jamieson, Galt; Misses H. Kerr, H. D. Muir, J. M. Wilson and Mrs. J. N. Mitchell, Brantford.

The monthly meeting of the Alumnae Association of the Brantford General Hospital was held in the Nurses Residence, December 1st, with twenty-two members present. Following the regular business meeting bridge was played at five tables.

The Brantford General Hospital was a writing centre in connection with the Provincial Registration Examinations, November 25, 26 and 27. Eighteen candidates wrote.

A new feature in the education of the student nurses at the Brantford General Hospital, was the visit of the students studying bacteriology to the water-works to observe the purification of water from the time it leaves the river until it reaches the taps in the homes. Another morning was spent visiting a modern pasteurization plant to study the receiving, testing, pasteurization and transportation of milk. Dr. M. S. Cole, lecturer in Bacteriology, conducted these excursions. The senior class visited the Ontario School for the Blind, Brantford, in connection with their lectures on eye diseases, and after hearing and observing the work done by many blind students, met in the Assembly Hall to study a number of the various types of eye conditions interfering with sight, and to learn a little of the history of each. In addition to being privileged to see these eye cases, one was impressed with the importance of prevention, as well as nursing care, and a third lesson gleaned from this excursion was the stimulus to each one to make the most of their own opportunities, Dr. N. W. Bragg, E.E.N. & T. specialist, conducted this excursion.

Re Red Cross Home Nursing Classes: Miss Nellie Yardley (Brantford General Hospital, 1927) has been appointed local organizer for Brantford and surrounding district. Two classes have already started and are being taught by Miss Dora Arnold and Miss C. Good.

Mrs. J. N. Mitchell, V.O.N., and Miss E. M. McKee, Superintendent, Brantford General Hospital, attended the annual meeting of the Ontario Red Cross in Toronto on Friday, November 27th, 1931.

Mrs. H. P. Plumptre, Toronto, was a recent guest of the Local Council of Women, Brantford, and spoke on the League of

Nations. The following nurses attended: Misses G. V. Westbrooke, J. M. Wilson, L. R. Gillespie, E. M. McKee, Mrs. J. N. Mitchell, Mrs. M. H. MacBride.

The Florence Nightingale Association met in the Nurses Residence, Brantford General Hospital, December 7, for the purpose of making Christmas favours for the ward trays.

Through the generosity of the merchants of Brantford a very excellent Santa Claus parade visited the hospital. The cavalry and the musicians congregated in the courtyard and performed for the children and other patients, while the masqueraders paraded through the hospital distributing goodies to the patients.

GENERAL HOSPITAL, GUELPH: The Alumnae of the Guelph General Hospital are holding a weekly bridge to aid Miss Ethel Eby, Public Health Nurse, with the city relief milk fund. An operating room note book has been established for the use of the graduate nurses and may be procured at a small fee.

ST. JOSEPH'S HOSPITAL, GUELPH: A dance was held by the St. Joseph's Alumnae in the Ryan Auditorium, Friday, November 27th, 1931, with a good attendance.

DISTRICT 4

HAMILTON: The quarterly meeting of District 4, R.N.A.O., was held in the Senior Residence of the Hamilton General Hospital on October 17. Miss Anne Wright, chairman, presided. Following the business an interesting address was given by Miss Eileen McGregor, Occupational Therapist at the Mountain Sanatorium. Dr. R. J. Fraser, of the staff of St. Joseph's Hospital, addressed the meeting on "Spinal Anaesthesia," a subject of particular interest to all present.

ST. CATHERINES: The regular monthly meeting of the Mack Training School Alumnae was held at the Leonard Nurses Home with Miss Helen Brown presiding. During the lengthy business session arrangements were made for Christmas cheer and welfare. The Rev. Tuer then spoke on Social Service. The Alumnae Association held a bridge at the Leonard Nurses Home on December 2. The guests were received by Miss Helen Brown, President, and Miss Anne Wright. The committee in charge were: Miss Mildred Strong, Mrs. R. E. Elderkin, Mrs. Charles Hesburn, Mrs. E. Deware and Mrs. Lawrence Hepburn.

DISTRICT 5

A very successful meeting of District 5, R.N.A.O., was held at the Royal York Hotel, Toronto, on December 3, when one hundred and seventy members sat down to dinner at 7.30 p.m.

With members of the Executive at the head table were the speaker, Dr. John W. S. McCullough, and Mrs. McCullough, Miss Muriel MacKay, Miss Florence Emory, President of the Canadian Nurses Association, and Miss Mary Millman, President of the Registered Nurses Association of Ontario, who were also speakers.

Among the gay groups at small tables were out-of-town members from Collingwood and Oshawa who were motoring back after the meeting.

The Chairman, Miss Rhano Beamish, in her opening remarks referred to the privilege of District 5 in counting as members Miss Emory, President of the C.N.A., and Miss Millman, President of the R.N.A.O., and said that meetings of the district might be termed reunions of the child, the mother and the grandmother.

Miss Emory, leaving it to the membership to decide which was the grandmother, spoke of the Survey of Nursing Education recently completed by Dr. Weir, the report of which will shortly be released from the press. She asked the nurses to approach the study of the report with an open and unprejudiced mind in preparation for discussion of its findings and recommendations at the meeting of the C.N.A. in Saint John, June, 1932.

Miss Millman explained the dependence of the C.N.A. on the Provincial Associations for its membership since abolishing dual membership or membership through Alumnae Associations. Ontario having within its boundaries a larger number of nurses than any other province, had a very definite responsibility in recruiting members and supporting the C.N.A. In referring to the forthcoming report of the Survey, Miss Millman emphasized Miss Emory's appeal for intelligent study of its content. As convener of the programme committee for the annual meeting of the R.N.A.O. to be held in Ottawa during Easter week, Miss Millman gave a brief outline of the sessions when the report of the Survey will be discussed.

Miss Muriel MacKay, of the Hydro-Electric Commission, in her informal and charming way, gave a short history of the development of the work of the Nurse in Industry until the present time, when she holds a strong position in the field of public health.

Miss Ruby Hamilton, Chairman of the Community Health Association of Greater Toronto, introduced Dr. John W. S. McCullough, who, during the past summer travelled in Europe, making a survey for the Provincial Cancer Commission.

Dr. McCullough said he regretted very much being unable to discuss many of the observations and conclusions embodied in the report of the Commission, which is not yet released. But in spite of that he gave a very interesting and practical address from a nurse's point of view. He considers that the nurse has a very definite part to play in a preventive programme in educating the public in regard to early symptoms of cancer.

Miss Rowan moved a vote of thanks, which was heartily endorsed, and brought to a close one of the most enthusiastic meetings of the District.

TORONTO: The Board of Directors of the Hillcrest Convalescent Home at 1275 Bathurst St., Toronto, has undertaken a survey of the extent and nature of the need for convalescent care in Toronto. The survey is being carried on in co-operation with a council representing the hospital and community interests. Its purpose is three-fold: (1) to study the nature and extent of the

community need; (2) to study the use of existing resources and facilities; (3) to present the conclusions of the study to the community. Miss Laura A. Gamble, Reg.N., has been appointed director of the survey. Miss Gamble's office is at 1275 Bathurst St., Toronto.

WOMEN'S COLLEGE HOSPITAL, TORONTO: The annual election of officers was held at the Grenville Street Clinic on November 9. Miss Henry was given the chair by acclamation. It was decided that the Alumnae should hold a shower on December 14 for the Christmas Tree in aid of the Clinic. On November 28 the Alumnae held an enjoyable bridge party (32 tables) at the King Edward Hotel. Miss Meiklejohn, assisted by Miss Avery, received the guests. The success of the afternoon was due to the untiring efforts of Misses Fraser, M. Shaw, Dunning and Varey.

HOSPITAL FOR SICK CHILDREN, TORONTO: The December meeting of the Alumnae took place in the Nurses Residence on December 10. There was a large attendance and all came with generous armfuls of parcels for the Good Cheer baskets which were being packed by the Welfare Auxiliary. A very fine programme of Christmas music, readings and contests were given, and a delightful social "get-together" was enjoyed by everyone.

Dr. and Mrs. D. T. Kendrick (Irene Newcombe, Hospital for Sick Children, 1928) have returned to Toronto to reside. Miss Helen Boothe (1926), Miss Doris Bews (1923), and Miss Marjorie Henderson (1928), are attending the post-graduate course at the Mothercraft Centre, Toronto. Miss Jean Maston (1920) is in the operating room at the Pavilion at Toronto General Hospital. Mrs. Dunham is on the staff at the Preventorium Hospital. Sincerest sympathy is extended to Miss Reba Simpson in her recent bereavement.

DISTRICT 6

District No. 6, R.N.A.O., held its annual meeting in Port Hope Hospital, October 27, at 2.30 p.m. Thirty-five nurses, representatives from Port Hope, Coburg, Bowmanville, Lindsay, Fenelon Falls and Peterboro were present, with Miss R. Bell in the chair. The following officers were elected for 1932: Chairman, Miss R. Bell, General Hospital; Port Hope; Vice-Chairman, Miss Graham, Coburg; Secretary-Treasurer, Miss L. Simmons, Peterboro; Private Duty Section, Miss M. Watson, Peterboro; Public Health Section, Miss McKenzie, Lindsay; Nursing Education, Section, Mrs. Leeson, Nicholls Hospital, Peterboro; Convener Membership Committee, Miss Helen Anderson, Peterboro; Councillors, Miss F. Dixon, Peterboro; Miss Morrison, Lindsay; Miss Elliott, Port Hope; Mrs. Smythe, Bowmanville; Miss McIndoo, Belleville; Miss L. Gaden, Prince Edward County Hospital, Picton; Representative to "The Canadian Nurse," Miss E. Walsh, Nicholls Hospital, Peterboro.

The report of the committee on organisation of chapters within the district was read by Miss Dixon, Peterboro, and recommended the division into chapters as follows: (A) Prince Edward County and Hastings; (B) Northumberland and Durham; (C) Peterboro, Victoria and Haliburton. The committee recommended further that the district should elect to its executive two councillors from each chapter, and that these councillors should become chairman and vice-chairman of the chapter; that other officers of the chapter should be secretary-treasurer, convener of membership, and a councillor for each section. The committee wish it definitely understood that all members of chapters must be members of the R.N.A.O.

The following officers were elected for the chapters:

Chapter A (Prince Edward County and Hastings): Councillors, Miss McIndoo, Belleville; Miss Gaden, Prince Edward County Hospital, Picton. Convener of Nominating Committee, Miss Collier, Belleville.

Chapter B (Northumberland and Durham): Councillors, Miss Elliott, Port Hope; Mrs. Smythe, Bowmanville. Convener of Nominating Committee, Miss Rundle, Bowmanville.

Chapter C (Peterboro, Victoria and Haliburton): Councillors, Miss Dixon, Peterboro; Miss Morrison, Lindsay. Convener of Nominating Committee, Miss Reid, Lindsay.

A motion was passed that each chapter should raise money for a bank account and send local news items to Miss Walsh, publications convener for the district, before the fifth of each month, for publication in "The Canadian Nurse".

It was decided to hold the district meeting once a year. The meeting adjourned for tea, after which Dr. Stewart Cameron, Peterboro, gave a very interesting address on "The Survey of Nursing Education in Canada". Miss Dixon, seconded by Miss Watson, moved a vote of thanks to Dr. Cameron and also to Miss Elliott, Port Hope Hospital.

BELLEVILLE: The opening meeting of Belleville General Hospital Alumnae for the year 1931 and 1932 was held on October 6. A large number were present. Officers were elected for the year and tea was served at the close of the business meeting.

Miss Margaret Tait, former Superintendent of Belleville General Hospital, recently visited the city and received a warm welcome from the graduate nurses.

PETERBORO: A meeting for the reorganisation of Chapter C of District 6, R.N.A.O., was held at the Nurses Residence, Nicholls Hospital, Peterboro, on November 24, 1931, at 3 p.m., with a fair attendance. The following officers were elected: Chairman, Miss Dixon, Peterboro; Vice Chairman, Miss Morrison, Lindsay; Secretary-Treasurer, Miss Alice Price; Nursing Education Councillor, Miss Reid, Lindsay; Private Duty Councillor,

Mrs. La Plante; Public Health Councillor, Miss Jory; Convener of Membership, Miss McKinnon; Convener of Publication, Miss Edna Dawson; Convener of Programme Committee, Miss Simmons. It was decided that meetings be held in the evening, the first to be held in January, and that the membership fee be 25 cents.

The Nicholls Hospital Alumnae held their annual banquet on December 3. About seventy nurses assembled with a large number of guest nurses, graduates of other hospitals. The speaker of the evening, Rev. Dr. McLean, gave a very pleasing address. The toast proposed to The Guests by Miss Walsh was responded to by Miss Simmons. The toast to the Old and New Graduates by Miss McBrien was responded to by Miss Anderson, president of the Alumnae. The toast to "The Alma Mater" by Miss Smith, was responded to by Mrs. Leeson, Superintendent. Miss Dixon, past president of the Alumnae, gave a very instructive talk on organising a chapter for the district. An enjoyable dinner was brought to a close by singing of "Auld Lang Syne".

DISTRICT 8

Members of District No. 8, R.N.A.O., held an interesting meeting on November 4 at the Royal Ottawa Sanatorium. One hundred and nineteen members attended. Miss Dorothy Percy presided in the absence of the Chairman, Miss Alice Ahern. The members listened to an excellent address on "Modern Treatment of Tuberculosis" by Dr. D. A. Carmichael. A symposium on Tuberculosis was given (1) by Miss Jean Church on "Responsibility of Private Duty Nurse in Tuberculosis"; (2) by Miss Marjorie Robertson, who gave a paper on "Public Health Work in Tuberculosis Nursing"; and (3) by Miss Mabel M. Stewart who spoke on "The Role and Opportunities of the Institutional Nurse in Tuberculosis Nursing". Dr. R. E. Wodehouse, Secretary of the Anti-Tuberculosis Association, gave a very interesting address on "Sanatorium Economics and Diagnostic Service".

Misses Helen Smith, Ida McDowell, Jean Forbes and Lillian Garrett of the Ottawa Civic Hospital, are at present attending McGill University.

GENERAL HOSPITAL, OTTAWA: Under patronage of Mayor Allen of Ottawa and Mrs. Allen, the Nurses Alumnae of the Ottawa General Hospital held a charmingly arranged supper dance at the Chateau Laurier on November 18. This event, attended by more than four hundred people, was most enjoyable. The hostesses of the evening were Lady Clark, wife of the High Commissioner of Great Britain, Mrs. L. Arthur Cannon, Mrs. J. J. Allen, Mrs. F. P. Quinn, Miss Juliette Robert, president of the Alumnae, and Miss Munro, convener of the dance committee.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The monthly meeting of the Alumnae Association was held at the Hospital. Dr. H.

S. Mitchell, Medical Superintendent, gave a most interesting talk on "Poliomyelitis" and demonstrated the uses of the new "Respirator". Miss Muriel Bazin, of the Hospital for Sick Children, Toronto, has joined the staff. Miss Alice Bell has resigned from the staff and is doing special duty. Miss Margaret Watson visited the hospital recently. It was with much sorrow that the members of the Alumnae Association learned of the death of Dr. Walcot, of Lachine. Deepest sympathy is extended to Mrs. Walcot (S. Bishop, Children's Memorial Hospital, 1912) and family.

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss Rae Fellowes, 1928, is now with the Social Service Department of the Royal Victoria Hospital. Miss Winnifred Wallace, 1918, has accepted the position of Assistant Superintendent of the Harbour Hospital, New York. Miss May Kinder, 1925, has resigned from the staff and has been succeeded by Miss Anna MacLeod, 1930.

WESTERN HOSPITAL, MONTREAL: The sympathy of the Alumnae Association is extended to Miss Olga McCrudden on the death of her aunt, Mrs. McNaughton. Recently Miss Freda Jawes (1924) paid the hospital a short visit. Miss M. Munro (1905) is now living in Kelowna, B.C. Miss Hilda Marjorie Smith, Trinidad, is taking a course in Public Health in England.

SHERBROOKE: On November 16 and 17 an Institute was held at the St. Vincent de Paul Hospital for Metropolitan nurses in individual districts in the Province of Quebec. Miss Alice Ahern, Assistant Superintendent of Nursing, presided. Others present were Miss M. Taschereau, Metropolitan Supervisor in charge of the Frontenac Office in Montreal, Miss J. Gauthier, nurse in charge of the Practice Centre, Miss H. Dupuis, Pre-natal Supervisor, and representatives of the local Medical Association, Victorian Order of Nurses, l'Assistance Maternelle and Child Welfare League. The Institute was most successful. The nurses were deeply interested and enthusiastic and felt that the various lectures and demonstrations and the contacts made had been very profitable.

GENERAL HOSPITAL, MONTREAL: Miss Edythe Ward (1923) is night supervisor and Miss Edith McQuisten (1925) is on floor duty at The Women's General Hospital, Montreal. Miss Louise Foss (1928) has taken a position in a doctor's office. Miss Margaret Campbell (1929) is relieving in the Social Service Department, Montreal General Hospital. The sympathy of the Association is extended to Miss Lucy White on the death of her father.

SASKATCHEWAN

MOOSE JAW: The graduates of the General Hospital have formed an Alumnae Association: Honorary Member, Mrs. M. A. Young, Superintendent; President, Miss L. Carter; Vice-President, Mrs. M. Fitzgerald; Secretary, Miss A. Cheavins; Corresponding Secretary, Miss E. Heglin; Treasurer, Miss G. Winsor.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

- BADGELY**—On September 22, 1931, at Detroit, Mich., to Dr. and Mrs. Carl E. Badgely (Florence Chandler, Sarnia General Hospital, 1919), a daughter.
- BROWN**—On October 29, 1931, at Sarnia, Ont., to Mr. and Mrs. Gordon Brown, Bridgen, Ont. (Margaret Noble, Sarnia General Hospital, 1919), a daughter.
- CHALMERS**—Recently, at Somerset, Man., to Mr. and Mrs. W. E. Chalmers (Mabel Horn, Winnipeg General Hospital, 1921), a daughter.
- CHESLEY**—On November 3, 1931, at Saint John, N.B., to Dr. and Mrs. Arthur Chesley (Beatrice Reed, Saint John General Hospital), a son.
- DODDS**—On November 8, 1931, to Mr. and Mrs. Wm. Dodds (Brenda Farmer, Winnipeg General Hospital, 1925), a daughter.
- ELLIS**—On November 1, 1931, at Saint John, N.B., to Mr. and Mrs. Harvey Ellis (Muriel Purdy, Saint John General Hospital, 1925), a son.
- FRASER**—On September 22, 1931, at Hamilton, to Dr. and Mrs. Fraser (Mildred Currie, St. Joseph's Hospital), a son.
- GRAY**—In September, 1931, at Hanover, Ont., to Mr. and Mrs. Euert Gray (Mary Clarke, Guelph General Hospital, 1927), a son.
- HARPER**—On November 26, 1931, at Vancouver, B.C., to Mr. and Mrs. William Harper (Florence Wray, Vancouver General Hospital), a daughter.
- JACKS**—On November 17, 1931, at Hamilton, to Mr. and Mrs. W. O. Jacks (Isobel Goodfellow, Hamilton General Hospital, 1930), a son (William John).
- LEE**—On November 2, 1931, at Vancouver, B.C., to Mr. and Mrs. William C. Lee (Dorothy Graham, Vancouver General Hospital), a son.
- LOUGHEED**—On November 24, 1931, at Hamilton, to Mr. and Mrs. John Lougheed (Susan Ramsay, Hamilton General Hospital, 1929), a daughter (Jacqueline Isabel).
- MASON**—On November 1, 1931, at Winnipeg, to Mr. and Mrs. Mason (A. Pilgrim, Winnipeg General Hospital, 1930), a son.
- McLEAN**—On November 22, 1931, at New Orleans, Louisiana, to Dr. and Mrs. Bazil McLean (Carrie Davis, Montreal General Hospital, 1920), a son.
- MacMILLAN**—On October 14, 1931, at Vancouver, B.C., to Mr. and Mrs. Hugh MacMillan (Dorothy Hall, Vancouver General Hospital), a daughter.

- MERRITT**—On November 9, 1931, at Winnipeg, to Dr. and Mrs. Paul Merritt (Violet Neelin, Winnipeg General Hospital, 1928), a daughter.
- MOODIE**—On October 13, 1931, at Kitchener, to Mr. and Mrs. Moodie (Rose Schmalz, St. Joseph's Hospital, Hamilton, 1925), a son.
- MOORE**—One June 18, 1931, at Waltham, Mass., to Dr. and Mrs. Clifford D. Moore (Alfreda M. Morley, Kingston General Hospital, 1928), a son (Clifford Douglas).
- STEVENS**—On September 12, 1931, at McKay Memorial Hospital, Taihaku, Formosa, Japan, to Dr. and Mrs. Eugene Stevens (Queenie Harris, Victoria Hospital, London, 1928), a son (Robert Eugene).
- WARICK**—On November 7, 1931, at Winnipeg, to Mr. and Mrs. A. H. Warick (Kay Yellowlees, Winnipeg General Hospital, 1930), a son.
- WHITE**—In October, 1931, at Sudbury, Ont., to Mr. and Mrs. R. B. White (Olive Dawson, Nicholls Hospital, Peterboro, 1926), a daughter.
- WILSON**—On September 2, 1931, at St. Catharines, to Mr. and Mrs. M. Wilson (Anna Gayman, St. Catharines General Hospital, 1927), a daughter (Barbara Marie).
- WOODS**—On November 20, 1931, at Vancouver, B.C., to Mr. and Mrs. F. G. C. Wood (Beatrice Fordham Johnson), a daughter.
- ZERON**—On August 11, 1931, at Faron's Point, Ont., to Mr. and Mrs. Wilfred Zeron (Alice Ford, Toronto Western Hospital, 1919), twin girls.

MARRIAGES

- ALBRIGHT-GRAY**—On August 13, 1931, at Cleveland, Ohio, Vera Gray (St. Joseph's Hospital, Hamilton, 1925), to G. Albright, of Cleveland.
- ANDREWS-SIMPSON**—On September 12, 1931, at Lonsdale, Ont., Miss G. Simpson (Belleville General Hospital), to Mr. J. Andrews, of Belleville, Ont.
- ANNABLE-BELFORD**—On November 28, 1931, at Ottawa, Garuer L. Belford (Montreal General Hospital, 1926), to H. R. Annable, of Montreal.
- BAUMAN-GRAHAM**—On August 25, 1931, at Westmeath, Edna Marion Graham (Ottawa Civic Hospital, 1931), to Bert Eric Bauman, of Arvida, P.Q.
- BENNETT-FAULKNER**—On September 5, 1931, at Port Dover, Ont., Helen Faulkner (Hamilton General Hospital, 1926), to William Roy Bennett, of Toronto.

- BLACK—EARLE**—On November 14, 1931, at Brockville, Ont., A. B. Earle (Belleville General Hospital), to S. Black, of Huffs Island, Ont.
- BROWN—EMERSON**—On November 21, 1931, at Caledonia, Ont., Annie Emerson (Hamilton General Hospital, 1929), to Frederick Brown.
- BURN—MONTGOMERY**—On September 5, 1931, at Montreal, Jean Montgomery (Royal Victoria Hospital, 1929), to Grant Burn.
- CAMPBELL—MALLABY**—On November 21, 1931, at Toronto, Rhoda Mallaby (Grace Hospital, Toronto, 1924), to George Herbert Campbell.
- COATES—HOUGH**—On November 14, 1931, Annabelle Hough (Brantford General Hospital, 1922), to Dr. L. H. Coates, Brantford. Dr. and Mrs. Coates will reside at 133 Brant Avenue, Brantford.
- CHRISTIE—SMITH**—On October 17, 1931, at Lachute, Que., Doris Smith (Homoepathic Hospital, Montreal, 1923), to J. Keith Christie, of Lachute. Residing in Montreal.
- COTES—STEVEN**—On September 23, 1931, at Chicago, Grace E. Steven (Regina General Hospital, 1916), to Monroe E. Cotes. At home 2628 Burling Street, Chicago.
- FARMER—SCOTT**—At Toronto, Luella Scott (Toronto General Hospital, 1930), to Dr. Alfred Farmer.
- GRIFFIN—COATES**—Recently, at Oliver, B.C., Helen Jean Coates (Hospital for Sick Children, 1928), to Benjamin Griffin, of Oliver, B.C.
- HAMILTON—GUGIN**—On August 22, 1931, at Minnedosa, Man., Helen Gugin (Winnipeg General Hospital, 1929), to John Hamilton, of Winnipeg.
- HALL—WHYTE**—On September 12, 1931, at Montreal, Elizabeth Whyte (Royal Victoria Hospital, 1928), to T. Hall.
- HAMILTON—KEFFER**—On November 7, 1931, at Brantford, Florence W. Keffer (Brantford General Hospital, 1928), to Reginald H. Hamilton.
- HARRIS—DOUQUETTE**—At Ottawa recently, Ruth Marguerite Duquette (Ottawa Civic Hospital, 1929), to Frederick Seymour Harris, of Ottawa.
- HILYER—REID**—On November 14, 1931, at Toronto, Agnes Josephine Reid (Grace Hospital, Toronto, 1920), to Clarence H. Hilyer.
- HOPPER—DILLABOGH**—In August, 1931, Velma Clarissa Dillabogh (Ottawa Civic Hospital, 1929), to Charles Watson Hopper, of Westboro.
- HOWLETT—CHISHOLM**—On November 21, 1931, at Montreal, Beryl M. Chisholm (Montreal General Hospital, 1929), to Dr. Leslie E. Howlett, of Ottawa.
- HUTCHINSON—ARMSTRONG**—On October 12, 1931, at Bailieboro, Isobel Armstrong (Nicholls Hospital, Peterboro, 1925), to William Hutchinson.
- JOHNSTON—RICHARDSON**—On September 26, 1931, at Queensville, Ont., Priscilla Viola Richardson (Toronto Western Hospital, 1927), to Dr. Cameron L. Johnston.
- KNEIRMIER—KELLY**—On August 24, 1931, at Hamilton, Ethel Kelly (St. Joseph's Hospital, Hamilton), to Matthew Kneirmier, of New York City.
- KNIFFEN—BURRILL**—On September 29, 1931, in Montreal, Marjorie Jean Burrill (Homoepathic Hospital of Montreal, 1930), to Leslie Kniffen. Residing in Montreal.
- LAMBERTS—CUMMERFORD**—On September 5, 1931, at Thorald, Adelaid Cummerford (St. Joseph's Hospital, Hamilton, 1928), to Gordon Lamberts, of Walkerton, Ont.
- LAMONT—REED**—On August 4, 1931, at Ottawa, Gladys Maude Reed (Lady Stanley Institute), to Sergt. Hugh McKirdy Lamont, of the Canadian Legation, Washington.
- LENEY—STEEL**—At Montreal recently, Florence Steel (Royal Victoria Hospital, 1922), to W. Loney.
- LESTER—BYRNES**—On July 29, 1931, at Guelph, Laura Byrnes (St. Joseph's Hospital, Hamilton, 1930), to Call Lester, of Guelph, Ont.
- LINDSAY—CARRUTHERS**—On August 28, 1931, at Inglewood, N.J., Alma Irene Carruthers (Victoria Hospital, London, 1929), to Dr. Kenneth Lindsay, of Buffalo, N.Y.
- MARSHALL—AULT**—On August 18, 1931, at Brinston, Ont., Beulah Ault (Brockville General Hospital, 1929), to William Marshall, South Mountain, Ont.
- MCCOLLUM—BALLAGH**—Recently at Teeswater, Jessie Ballagh (Hospital for Sick Children, 1928), to Dr. Hugh McCollum, of London, Ont. Dr. and Mrs. McCollum have taken up residence at Teeswater.
- McKINNEY—McMANN**—On November 14, 1931, at Cold Springs, Ont., Lilly Irene McMann (Grace Hospital, Toronto, 1930), to Dr. John Henry McKinney, of Brooklyn, Ont.
- McMACKLIN—CROCKETT**—On November 7, 1931, in Saint John, N.B., Margaret Crockett (Saint John General Hospital, 1931), to Edward McMacklin.
- MELDRUM—PLACE**—On September 5, 1931, at Prescott, Ont., Alda Eunice Place (Ottawa Civic Hospital, 1927), to Lorne Alexander Meldrum, of Ottawa.

MONYPENNY—CLARK—On October 28, 1931, at Toronto, Vera Madeline Clark (Toronto General Hospital, 1928), to Arthur Douglas Monypenny.

NORMAN—DEVINE—On October 28, 1931, at Toronto, Coral M. Devine (Toronto Western Hospital, 1929), to Alfred W. Norman. At home, 530 Strathmore Blvd., Toronto.

NESBITT—LAWFORD—On September 3, 1931, at Winnipeg, Flora Lawford (Winnipeg General Hospital, 1906), to N. L. Nesbitt, of Chicago, Ill.

PARMALEE—STITT—On September 12, 1931, at Fort Coulonge, P.Q., Lillas Stitt (Ottawa Civic Hospital, 1926), to Wilfred Alexander Parmalee, of Ottawa.

SAMPLE—GIBSON—On October 16, 1931, at Sarnia, Ont., Margaret J. Gibson (Public General Hospital, Chatham, 1930), to Clarence Sample, of Chatham, Ont.

SCANLON—MURRAY—On December 5, 1931, at Vancouver, B.C., Alfreda Murray (Vancouver General Hospital), to Robert H. Scanlon, of Powell River, B.C.

SKARRETT—WOOD—In November, 1931, at Guelph, Ont., Olive Wood (Guelph General Hospital, 1931), to Clyde Skarrett, Sarnia.

STAHL—GRAHAM—On October 5, 1931, at Alliston, Ont., Doris A. Graham (Toronto Western Hospital, 1929), to Dr. Oscar Stahl, of Timmins, Ont.

WEDLOCK—ADAMS—In September, 1931, at Peterboro, Ont., Daisy Adams (Nicholls Hospital, Peterboro, 1926), to William Wedlock.

WELCH—PEAT—On November 21, 1931, in Edmonton, Alta., Louise B. Peat (Toronto Western Hospital, 1916, also of the C.A.M.C.), to Gilbert W. Welch, of Port Rush, Ireland.

DEATHS

AIKMAN—On December 3, 1931, at Winnipeg, after a lengthy illness, Elizabeth Ramsey Aikman (Winnipeg General Hospital, 1912, and British Red Cross and Canadian Army Medical Corps Nursing Service, 1914-1918).

DeVOIN—Suddenly, on November 20, 1931, at Smithers, B.C., Mrs. DeVoia, formerly Nursing Sister Gertrude Everleigh.

LOUCKS—On November 29, 1931, at Montreal, Mrs. Loucks (Lyle Weston, Montreal General Hospital, 1895).



THE CANADIAN NURSE

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

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Regular Meeting—First Thursday of each month.

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A.A., ST. LUKE'S HOSPITAL, OTTAWA

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

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Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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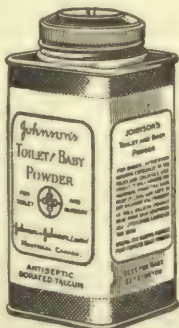
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Neuro-Surgical Nursing

By KATHERINE S. JAMER, Royal Victoria Hospital, Montreal

It is impossible in the short time at our disposal to give more than a few outstanding points in the nursing care of neuro-surgical patients. Certain it is that the nurse attempting to care for such patients should have at least a general idea of the nervous system and of what is indicated by certain symptoms and conditions.

Major neuro-surgical operations may be divided into four groups:

1. Fractures } which from a nursing point of view are
2. Bone flaps } much the same.
3. Cerebellar cases.
4. Laminectomies.

Whether the operation is necessary because of tumors, abscesses, cysts or injury, the nursing care is the same in each group.

Outstanding points in the care of each follow:

Post-Operative Bone Flap or Skull Fracture

The greatest danger is from bleeding and clot formation. We are all familiar with the usual symptoms of bleeding, including rapid, weak pulse, quickened or sighing respirations, but these do not pertain here because the loss of blood is very slight. Pulse and respirations are both slow and depressed. The source of danger is the clot. This may be indicated by pressure symptoms or by local symptoms. Pressure symptoms include:

1. Restlessness;
2. Drowsiness—leading to coma;
3. Headache;
4. And most important—falling off of responses.

Local symptoms include:

1. Hand grip: The nurse should always test the patient's hand grip (as well as observe him generally), on return from the operating room, so that she may report any changes in later hours.

2. Convulsions.

3. Headache.

4. Speech disturbances.

Any of these symptoms should be reported immediately.

Cerebellar Cases

Because cerebellar operations naturally mean pressure upon and disturbance of the medulla, the pulse and respirations are slowed and depressed, sometimes to an alarming degree. This explains the q. 15-minute pulse and respiration chart. This depression is present in all intracranial conditions, but more particularly in cerebellar cases.

Also, because of interference with the heat regulation centre, the patient may develop a "central heat" or "central temperature," at times rising as high as 106° and 107°. Temperatures, when contra-indicated by mouth, are always taken rectally. Clothing and bed coverings are adjusted to suit the temperature. With hyperpyrexia no covering other than a sheet is used on the patient.

Cerebellar cases often have no swallowing reflex left, and nasal feeding must be carried on as long as necessary. The patient is kept face down while this condition lasts so that mucus and saliva will run out of the mouth instead of down the trachea. Should paralysis affect only one side of the throat, the patient is fed lying on the good side. This lessens the danger of food being lodged in the throat and breathed into the lungs.

(A paper read at the Association of Registered Nurses of the Province of Quebec meeting, held in the Montreal General Hospital, December 1st, 1931.)

Pre-operative enemata, with cerebellar patients, are extremely dangerous and have been known to cause the death of the patient. This is because the blood which is forced out of the abdominal organs by the strain of expelling the enema is forced into an already crowded space within the skull. This results in the medulla being forced into the upper part of the spinal canal and so compressed that it ceases to function.

A Murphy drip of magnesium sulphate may, however, be ordered, for the combined purpose of reducing pressure and cleansing the lower bowel.

Laminectomies (including fracture of the vertebrae): These result in anaesthesia of the parts below the lesion, and trophic disturbances: proper nourishment is not being supplied and resistive power is very low. Because of sensory impairment, a hot water bottle must *never* be used with a laminectomy patient, since even a moderately heated bottle may cause a severe burn without the patient's knowledge. The patient must be turned frequently—the spine being carefully supported—for rubbing and changing points of pressure, also to prevent hypostatic pneumonia. He must be kept scrupulously dry and clean. A pressure sore once begun progresses rapidly and is extremely difficult to heal.

Constipation and retention may follow operation, later succeeded by incontinence due to loss of sphincter control. This demands unlimited care and preventive measures.

Other nursing responsibilities in connection with neuro-surgery include: Accurate observations of convulsions or epileptic attacks. Careful records of the beginning, spread and duration of attacks may be invaluable aids to diagnosis.

Great difficulty is often experienced in keeping post-operative patients quiet and restraints may have to be used, but such restraints must be so applied as not to interfere with cir-

culatation in any way. The intracranial case must be regarded as potentially unbalanced mentally for the time being. Consequently he cannot be trusted and must be watched *all* the time.

The head of the bed is elevated as ordered, usually three notches, to prevent oedema of the brain. Only when the symptoms of shock overbalance the danger of oedema of the brain is the foot of the bed elevated instead of the head.

Drugs are used very little because further depression is undesirable. The blood pressure chart gives important information about the patient's condition. Shock and collapse are indicated by a fall of blood pressure, increased intracranial pressure by increased blood pressure, and failure of the medullary centre causes a sudden drop in a blood pressure which may have been rising steadily towards the normal.

Care of the mouth is important in every case.

Dressings for neuro-surgical cases consume a great deal of time and require careful technique. The meninges possess no resistance to infection, therefore any break in technique may result in the loss of the patient's life.

Finally, we should consider the mental attitude of the patient, who is often unfit for work for a very long period of time. During convalescence he may be taught many things about caring for himself, e.g., a tic douloureux patient, cured by root resection, will have a permanent paralysis of one side of his face. He must be taught to protect and care for the eye on that side, since foreign bodies which he cannot feel may cause corneal ulceration, which may result in the loss of his eye.

Hope and courage should be sustained. To this end current events, books and the patient's surroundings should play an important part. Tact and resourcefulness are almost as important nursing attributes as observation and intelligence.

Editorials

EASTWARD HO!

The tang of sea breezes, the lure of the mountains and the hospitality of the United Empire Loyalist combine to make Saint John an ideal city for conventions. Are you including the biennial meeting of the Canadian Nurses Association in your professional and holiday plans? All roads will lead to Saint John the last week of June, the twenty-first to the twenty-fifth to be specific. Added to the attractions of the convention city in particular and to the Maritimes in general is the content of the programme itself. The Report of the Survey of Nursing Education in Canada is accentuated as reflected in a tentative outline appearing in this issue. The sessions are devoted to a discussion of the salient recommendations of the Report and to business.

What of the intellectual menu? The programme committee has exercised meticulous care in a choice of guest speakers and has been singularly rewarded by the acceptance of those who have made a distinctive contribution to thought and practice, each in his own field. The Hon. Vincent Massey, LL.D., will discuss the report from the angle of the public, Professor F. Clarke of McGill University from the standpoint of the educationist, and Dr. G. Stewart Cameron will interpret the attitude of the medical profession. Professor Roy Fraser, Mount Allison University, our dinner speaker, will contribute the viewpoint of the scientist.

Nor has the practical aspect of nursing problems been neglected. Three general sessions are devoted to three salient features of the Report: that is, recommendations regarding the Approved Training School, the Cost Analysis of Nursing Education and the Distribution of Nursing Service. Sub-topics relative to each will be discussed briefly by selected nurses throughout the Dominion. Each of the three sessions will be introduced by a nurse member of the Joint Study Committee,

who will summarise discussion and present related resolutions for group consideration. Ample time is reserved for general discussion. Section sessions under process of preparation will reflect similar care in respect of content and presentation.

Hospitality, arranged by our hostesses, the New Brunswick nurses, promises to be as unique as it is genuine. Plans divulged by the Convener of the Arrangements Committee testify to that.

Already many look eastward to the biennial convention and to a restful holiday in the Maritimes. Their purpose is to combine a collective, dispassionate study of nursing problems with subsequent leisure. Will you join them?—F.H.M.E.

SCHOOL INSPECTION IN ALBERTA

The University of Alberta, which is responsible for the standard of nursing education outlined by the Alberta Association of Registered Nurses, has recently appointed, on request from the Association, a Committee of Inspection for schools of nursing in that province.

The personnel of the committee has been drawn from members of the Senate of the University and represents the medical and nursing professions and the public; thus the close corporation idea in regard to the nursing profession is done away with and the responsibilities of the committee placed on more general educational basis. The members of the committee are: Dr. J. J. Ower, of the Faculty of Medicine and Provincial Pathologist; Mr. A. E. Ottewell, Registrar, University of Alberta; and Miss Eleanor McPhedran, President, Alberta Association of Registered Nurses and Superintendent of Nurses, Central Alberta Sanatorium. Miss McPhedran's appointment has the whole-

hearted approval of the Association; with her wide experience she will undoubtedly prove to be a valuable member of the committee.

Miss McPhedran commenced her professional career as a teacher, but soon abandoned that and entered the New York Hospital at a time when Miss Annie Goodrich was superintendent of nursing. After graduation, several years were spent in hospital work and private duty nursing; then Miss McPhedran accepted the position of assistant superintendent at the Calgary General Hospital, and for the past twenty years her professional interests have been centred in the province of Alberta.

A pioneer in school nursing in Western Canada, Miss McPhedran served in that capacity with the Calgary School Board for three years; then she took charge of the newly-established Hospital for Returned Soldiers. This led to an appointment

for overseas service, and early in 1917 she arrived at No. 9 Canadian General Hospital at Shorncliffe. Later a term of service was spent at No. 2 Canadian General Hospital at Le Treport in France, then again at No. 9, and also in North Wales. When the Department of Soldiers' Civil Re-establishment took over the Belcher Hospital, Calgary, Miss McPhedran was appointed matron, and in 1920 she was transferred to a similar position on the opening of the Central Alberta Sanatorium. For the past six years this institution has been under the direction of the Health Department of Alberta.

Miss McPhedran has been associated with the provincial nursing organisation since its inception in 1912, acting as secretary for six years, and as president for the past four. Since 1926 she has represented the nurses on the Senate of the University of Alberta.

MISS EDNA MOORE RETURNS TO CANADA

The return of Miss Edna Moore to the staff of the Provincial Department of Health of Ontario was welcomed not only by her former associates in that department, but by those interested in the field of public health nursing in the province.

Miss Moore assumed the position of Chief Public Health Nurse for the province on December 1st, 1931, bringing to this position a wide knowledge of the field of public health nursing, particularly from the administrative angle. Her experience, both in Canada and the United States, makes her fully aware of the prob-

lems which confront the nurse engaged in any and all types of communities, and she has the added advantage of coming to her new field of effort without bias and with one objective only, namely, to establish public health nursing on the plane which is should unquestionably occupy in the province in which she is employed.

Both her friends and acquaintances will follow her efforts with interest; that she is assured of the fullest co-operation of all those, either directly or indirectly associated with public health, may be taken for granted.

J. T. P.

The Relation of the Dietary Department to the Hospital

By SISTER KENNY, Hotel Dieu, Chatham, New Brunswick

Those of us who have seen service in the hospital field during the past quarter of a century are struck with amazement and pride at the gigantic strides science has made in the perfecting of every branch of hospital work. The American College of Surgeons was responsible for the explosion of the bomb, which, after unsettling many institutions, ended gloriously in bringing into standardisation line many hospitals which of themselves would never have arisen out of the rut of monotonous inferiority. Mr. Robert Jolly's humorous account of his disregard of standardisation literature, and of his subsequent tragic encounter with the college member on his first survey, might be reproduced in many institutions. But the American College of Surgeons meant business, it had perfect organisation, and in time institutions for the care of the sick came to realise that they had to submit to its requirements or be wiped off the hospital map. Every institution represented here today has satisfied the exactions of the minimum standard, and many are doing much more. Realising the great benefit of standardisation, and being fired with greater enthusiasm for the betterment of hospitals, a new need was created, that of closer co-operation, a more friendly feeling between institutions. This was met by the formation of hospital associations. These associations have been a real boon to hospital executives. Whereas formerly hospitals functioned independently of each other, neither knowing nor caring how the others fared, now there is the bond of union, the pooling of problems and experiences, transferring worries from the overwrought shoulders of the administration to the whole association, where many minds

and united efforts easily solve the apparently insurmountable obstacles.

The end and object of all these noble enterprises, be they standardisation movement or the formation of associations, is ever and always the greater good of the patient. The patient is the centre, towards which converge all our efforts and strivings—the very reason for the existence of our imposing structures, and for the high education of doctors and nurses. The American College of Surgeons made wise choice of the minimum standard in insuring safety and protection to the patient. There is, however, one department of prime importance on which, I venture to say, the reputation of a hospital depends, whereby its good name is made or marred—I refer to the dietary department.

Let me appeal to the medical man—has it not frequently happened, in the treatment of disease, that careful attention to diet has saved the life of your patient? Must you not acknowledge that in many instances a cure could have been effected if anyone had been at hand to correctly select and prepare the prescribed food? Not many of the laity select a certain hospital solely because it keeps correct case records, or because it has a good laboratory, holds regulation staff meetings, has a wonderful x-ray, or indeed because fee-splitting is unknown within its precincts. These five points are excellent, and call for unstinted praise; but, in reality, what do we hear current among convalescents or those lately discharged from hospitals? Is it not something similar to this: "I wouldn't go to any other hospital—the meals are so good here—every day is like a picnic"; or, "In this institution one just has to eat, the trays look so inviting"? Or do we hear: "I'll never go back to that hospital; I was starved, the food was

never hot or I had to send home for little dainties—the tray service was uncouth——”?

Now as we are engaged in hospital work primarily for the good of the patient, his welfare and comfort must be dominant. Observation extending over years has convinced us that if the patient is satisfied with his diet, he is satisfied with everything. Psychology teaches that a contented mind is the prime essential for the cure of any ailment. What is more conducive to this end than meals which are satisfying? We do well to listen willingly to the observations, even the complaints of patients and their friends; we often learn much for the betterment of the whole institution. We observe that our patients expect to get good food, well cooked—served hot—in sufficient quantity—to suit individual tastes.

Let us treat these four points more in detail. Food for the sick should be, first, *of very best quality*. False economy should never tempt us to profit of a bargain by stocking our hospital storeroom with any food of an inferior grade. In this branch of work the best is always the cheapest. The bread, milk and cream, butter and eggs, meat and vegetables and fruit should be of the best quality. But when the purchasing agent has faithfully attended to all this, there yet remains a very important part—the proper cooking or preparation of the food. It is necessary that the food contain sufficient nourishment, be tasty, present an attractive appearance, and last but not least, be economically handled. A little further on I will describe the person fully qualified to accomplish these results.

Second point: *Served hot*. How often have administrators been confronted with the complaint—the meals are not hot? To overcome this difficulty we must enlist the co-operation of every individual concerned with the food service. Certainly the food must leave the main kitchen hot, reach the floors by rapid transit, and then be served expeditiously on its

arrival there. This applies either to service from a central kitchen or by way of a diet kitchen. In this respect the senior nurse on the floor should be well impressed with the necessity of personally supervising tray service and not be allowed to relegate this very important duty to young and inexperienced nurses.

In treating the third point, I would like to say that it is an unpardonable offence against any hospital to have it said that patients have to buy food or have it brought from home. While we cannot credit even a fraction of such remarks made by patients, yet it is a fact that many complaints arise from the above source. While we serve bountifully to all who are allowed full diet, we must also remember that “too far east is west!” A heaped up tray placed before a delicate convalescent has the effect of spoiling whatever little appetite the patient had. A reasonable-sized serving, with the assurance that plenty more may be had on request, seems to be best. Sick persons may also require a light lunch at frequent intervals, when a full meal cannot be taken.

The fourth and last point: *to suit the individual tastes*. This is perhaps the greatest difficulty to surmount, as patients are strangers to us, of different nationalities and tastes, and we know that what is one man's meat is often another man's poison. To overcome this, all engaged in the hospital must be convinced that they are dealing with sick people, who are for the time being abnormal, nervous, irritable and hard to please. Unless this be kept in mind, we may look with scant sympathy on their apparently unreasonable idiosyncrasies and consider them fussy or cranky. This should be guarded against, because has not experience taught us that sickness often sours, temporarily, even the best disposition, and when restored to health our most difficult patients have often proved our warmest friends and our most grateful patrons? Experience may have taught

us that we, ourselves, are not proof against a little querulousness when some slight indisposition attacks us. Then I am strongly in favour of a special visit to each patient to ascertain his likes and dislikes. Why persist in serving foods we know the patient does not like? To say the least, it is poor economy, as we must discard all food left on a patient's tray, and it also needlessly annoys one already sensitive, and perhaps irritable. But, if we believe that satisfied patients constitute our best publicity, should we not endeavour to please all, and to send out each patient to sing the praises of the hospital where he has been treated? To sum up—to satisfactorily conduct a dietary department our aim must be to serve first-class food, well cooked, daintily presented, and to satisfy the needs and even the whims of our patients.

Now, I ask, on whom shall we place the responsibility of this very important department? Realising that in every hospital there is no one factor that contributes more largely to its general success or failure than the matter of diet, it follows that the person in charge must have special training; a broad, comprehensive plan of her work, and have acquired sufficient knowledge of dietary values. No longer may we send into our dietary laboratories the inexperienced, uneducated cook any more than we would engage the Sairy Gamp type on our nursing service. The day is past when any housemaid, who would hire for a reasonable sum, can be placed in charge of our dietary department, regardless of the fact that she never heard the terms: proteins, fats and carbohydrates, and thinks when she hears the nurses speak of calories that they are some new discovery in the line of "bugs." We would not entrust our surgical department to any but a very capable nurse, nor our pharmacy to an unregistered drug clerk, neither would we conscientiously confide so important a department as that of dietetics to any but a fully competent dietitian.

The ideal dietitian is one who, after graduating from high school, pursues a college course in Home Economics, then rounds out her science course by six months' practice under a qualified dietitian. I would add that to better care for the sick it is desirable that the dietitian be also a registered nurse. Would it be unkind to suggest further a period of illness to add a finishing touch, for nothing elicits sympathy for the sick as well as a personal acquaintance with illness? This education may seem extravagant, but do we realise that the food item represents 25 per cent. of the entire budget, and by placing a competent person in charge we judiciously cut down expenses by way of economy and by securing for our hospital satisfaction to the out-going patients?

The dietitian, if wisely chosen, will study the interests of the institution engaging her, will visit and strive to satisfy the varying whims of the sick, will be amenable to suggestions from the staff; differing in this from the proverbial cook, with fire in her eye when anyone accosts her, and who makes the kitchen a place where even the superintendent, unless clothed in a coat of mail, dare not trespass! Having secured a well-qualified, agreeable head for the dietary department, let us prove our appreciation by entrusting the welfare of this office confidently to her good judgment, and by listening with reason to requests for labour-saving devices and inventions which are nowhere more profitable than in this connection.

A student nurse's training is very inadequate without a proper conception of food values, special diets and the proper cooking and serving of her patients' meals. Who but the dietitian can supply this class work? Teaching nurses and taking care of special diets are not the only assignments of her rôle. She is the very embodiment of service and of proper sanitation. She is trained to make up properly balanced diets, and to

teach her patients the diet they must follow when they return home.

Hospitals, I repeat, are judged not only by the staff, the fine equipment, etc., but very largely by their courtesy, their service and by the meals they serve. Discourtesy and poor meals are two factors which cause the loss of many a potential patient and greatly irritate those under our care. A sick person's food must appeal to him. A tray with a soiled or carelessly arranged cover, mismatched china, and lukewarm, colorless, tasteless food tempts no one. It is a well-known fact that the spirit and attitude of the head of a department permeates the whole service. If the head or manager is courteous, punctual and obliging, soon every employee under her direction is doing her very best to have things just right; and to create a good feeling among the help is no small item. By visiting each patient several times a week, the dietitian is giving personal attention. Not only does she put the patient in a better frame of mind by merely calling on him, she also learns whether or not he is being satisfied. If she is responsible for all the food and its serving, and if she hears complaints first hand, is it not reasonable to expect her to correct these defects at once? The supervisor of the floor can and does listen to complaints about food, but can she always report the complaint without causing hard feelings and friction?

In pre-standardisation days we thought our hospitals were quite complete with no x-ray, a record department consisting only of clinical sheets and an order book, and a laboratory which we blush to recall, and we do well to remember the repeated appeals, the determined persuasion, even the very threats of being unclassified, which were needed on the part of the American College of Surgeons before we could be brought to see the necessity of standardisation requirements. It meant the outlay of a large amount of money, but the need was urgent, and we succeeded

somehow in co-operating. Now how much do we spend on our diet kitchen equipment? Is the kitchen a place we exhibit with pride to visitors, or do we quietly ignore it as our laboratory of years ago? Even though convinced of its importance, are we going to wait for some new urge from the American College of Surgeons before we equip and staff our kitchens as we know we should? When the dietitian asks for more equipment, investigate the matter with her, confer with reliable concerns about the merits of the suggested new devices, visit other modern hospitals to learn how they have solved their problems—then decide whether your dietitian is extravagant or not.

The nurses need nearly as much attention as the patients. Oftentimes a nurse is tired and discouraged when she comes down to the dinner table. If the meal is not the least bit attractive, she simply does not eat—and if this happens many times she becomes undernourished and even more disheartened. We expect nurses to radiate health and cheerfulness, but they cannot if they are not properly nourished. Let the dietitian help to create a cheerful dining room. She has had special instruction in house furnishing. She will keep the tableware well polished, have clean tablecloths at all times, even if they must be changed frequently, provide nourishing, tasty meals, served neatly and attractively. If a hospital is a place to restore health, why not make it a place to preserve it also?

In conclusion, let me again emphasize that the reputation of your hospital rests upon the meals you serve and how you serve them just as much as it does upon your x-ray facilities and your operating-room technique. When a properly organised dietary department has secured to your hospital satisfied patients, healthy contented nurses and employees, it will have taken its place with the most important departments in the hospital.

The Saint John Tuberculosis Hospital

The first hospital for the exclusive care of tuberculosis in the province of New Brunswick was founded in the city of Saint John to supply a growing need for the care of needy patients, and with the present viewpoint of the prevention of further disease. The institution was opened in December, 1915.

The original plant consisted of a main building, accommodating sixty patients, rooms for nurses, help, a power house and laundry; the whole

broken down with tuberculosis. A wing, accommodating forty service men, was added to the main building, thus increasing the accommodation to one hundred. In addition, the Dominion Government built a nurses' home and a superintendent's cottage.

In 1925, the staff of the hospital took over the medical work associated with the Free Tuberculosis Clinic, and this added much to the efficiency of the tuberculosis work of the city and county of Saint John, as it kept



SAINT JOHN COUNTY HOSPITAL FROM THE AIR

plant facing eastward, with its wide view of the Bay of Fundy.

Dr. H. A. Farris was appointed medical superintendent—a graduate of McGill (1907), who had splendid training in tuberculosis work. This began with a period of illness, followed by four years in Saranac Lake, six months in St. Agathe, a year at Calydor with Dr. C. D. Parfitt, a year as superintendent of Lake Edward Sanatorium. His influence in its years of development are everywhere evident.

During the war, the Dominion Government needed further accommodation for the ex-soldiers who had

a closer contact with dispensary and hospital, and allowed for an improved follow-up system. This clinic has grown until, at the present writing, some twenty-five to thirty patients are handled weekly and two visiting nurses carry on the follow-up work.

Dr. Farris, realising that the nurses in New Brunswick were not receiving training in tuberculosis work, began an affiliated course. At the beginning three months were given, but at present it has been reduced to two months. The course stresses the infectiousness of tuberculosis, and every attempt is made to insist that nurses learn the means of prevention of its spread, thus improving their protective tech-

nique. Eleven lectures are given, and the subjects are as follows:

- History of Tuberculosis;
- Tubercle Bacilli;
- Tuberculous Infection;
- Tuberculous Disease;
- Symptoms of Tuberculosis;
- Complications and Treatment of Tuberculosis;
- Drugs and Tuberculin;
- Home Treatment versus Institutional Treatment;
- Rest and Exercise;
- Anatomy and Pathology;
- Return to Health—Education of the Patient.

Use is made of practical demonstrations, moving pictures and any other means to impress the teaching. Practical care of the patients is also taught. At present there are nine affiliated schools, viz.:—Nova Scotia: The J. H. Dun Hospital, Bathurst; Yarmouth Hospital, Yarmouth; King's Memorial Hospital, Berwick. New Brunswick: Hotel Dieu of St. Joseph, Chatham; Victoria Public Hospital, Fredericton; Moncton City Hospital, Moncton; Chipman Memorial Hospital, St. Stephen; and the Saint John General Hospital; and P.E.I. Hospital, Charlottetown, P.E.I., with an annual turnover of nearly eighty nurses.

Each nurse is x-rayed, both antero-posteriorly and laterally, given a physical examination, a complete history is taken, and an intradermic test is done. A careful record is kept of each nurse, and a yearly follow-up for five years is carried out, the latter to give accurate future history of every nurse who has been in training, to determine, if possible, the association of the nurse with infection.

On completion of the course, every nurse is given a written and oral examination, and certificates are issued to those taking the course.

In 1924 the American College of Surgeons accepted the hospital as one of its standardised institutions, and

in 1926 it became a member of the American Hospital Association. In 1928 the institution was accepted as a special hospital for the training of internes.

An operating room was added and fully equipped to do chest surgery (thoracoplasty, phrenicotomy, thoracotomy, etc.)

At that time there was added a visiting staff for the departments of surgery—a senior and junior surgeon, and of medicine, nose, ear, and throat—x-ray and pediatrics.

Due to the generosity of Mr. A. J. Nesbitt, of Montreal, a two-storey, fire-proof building was added for the treatment of all forms of tuberculosis in children. This building has accommodation for fifty-two patients and maintains a teacher for older children and two kindergarten teachers for under-school-age children.

During the past year extensive changes have been made, consisting of the erection of an entrance lobby, after the manner of a hotel, a new front entrance in Colonial style, a sterilising and sitting room, and a re-cast of the x-ray, laboratory and help's dining room, an enlarged nurses' dining room, a cement tunnel connecting the nurses' home to the hospital, a new building for the housing of maids, an enlarged kitchen, new refrigeration and a diet kitchen with mechanical subveyor for the transportation of trays from the central diet kitchen to the floors, extensive landscaping of the entire grounds and a new superintendent's residence.

The present institution will accommodate two hundred and twelve patients, and is fully equipped to treat all forms of tuberculosis.

In 1930 Dr. Farris resigned to enter private practice and his position was filled by Dr. R. J. Collins, a graduate of Western Reserve University, Cleveland (1915), former superintendent of the Jordan Memorial Sanatorium at River Glade, N.B., and the Balfour Sanatorium, Balfour, B.C.

Care of the Mentally Ill

By MAY DAVISON, Woodstock, Ontario

The term Care of the Mentally Ill will convey to the minds of most people, perhaps, a deeper meaning than the newer terms Mental Hygiene and Psychiatric Nursing.

Mental diseases are hereditary, and, contrary to general opinion, mental cases as a rule are not dangerous to others, rather to themselves only. Never, if possible, should mental cases be kept at home; it is much better to have them in hospitals, particularly if there are children in the home.

On entering an Ontario Hospital a nurse or an attendant is first taught the need of custodial care: always to lock the door after a patient; not to lay down her keys or intrust them to a privileged patient. Keys have a habit of disappearing and patients are constantly alert to pick them up.

So-called nervous cases or mild mental cases (there is very slight difference) admitted to general hospitals, who are without severe pain or high temperature, are of very little interest to the busy general practitioner or the general duty nurse. Too often one hears, "What that patient requires is a good shaking," or "I'd like to slap her to make her snap out of it," without realising that these patients are mentally ill. The result is patients take a dislike to the doctor or nurse and are reluctant to discuss symptoms; they retire into themselves, become more depressed and make no progress toward recovery.

These patients, as well as the highly excited type with a capacity for work, are put to bed for absolute rest and feeding up for a period of six to eight weeks: they receive no letters, no visitors allowed or visitors restricted. Patients without visits from sympathising relatives and interfer-

ing friends make better progress than those allowed visitors. Frequently at the end of eight weeks such patients are allowed selected books to read, play solitaire, and later occupational therapy is introduced. This last plays a large part in the recovery of mental patients. Baths are given; first the bed bath, then later tub baths followed by an alcohol rub or light massage, and needle showers, warm or cold, also followed by massage.

Depressant patients are put to bed for absolute rest and feeding, and if possible the cause of depression must be discovered. Some go back to childish grievances or fears, as some constriction of throat or stomach, or lacking some organ, fear of falling down stairs, knives, people are talking about them, or poisoned food with refusal to eat. Take a spoon and show them you will eat the same food and persist in trying to reassure the patient that she is quite all right. On recovery patients will discuss with the doctors the dreadful thoughts they had and thus help the doctors in their treatment of similar cases. Depressant patients are given bed or tub baths, followed by an alcohol rub or massage; needle showers, hot or cold, or in some cases the continuous bath.

Never put an excitable, nervous patient in the continuous bath by wrapping the patient in a blanket and forcing her in the tub, but give a sedative first till the patient is in a fit condition to enter the bath. This consists of a sort of hammock slung in the bath tub, the patient is covered with a sheet or canvas cover and the temperature of the water kept at ninety-six or ninety-eight degrees. Test the water every half hour, either with thermometer or back of the hand. Patients must be under constant supervision in case the "mixer" is not working properly and the patient is liable to be chilled or scalded.

(A paper read at the June, 1931, meeting of District 2, Registered Nurses Association of Ontario.)

Those of a suicidal tendency will watch for an opportunity to duck their head under cover; also, in some cases, there is the danger of collapse. The patient should not be left in the bath longer than eight hours, then given a rub down and rest and returned to the bath. Some patients are kept in the baths for weeks; some for a shorter period. If there is any tendency to a skin rash, rub the patient with vaseline or ointment. Very few general hospitals have facilities for a continuous bath to be given properly. These baths are not a new thing, Napoleon in his time was fond of them. Numbers of alcoholic patients have been admitted to hospital for continuous baths to aid them in sobering up.

Diathermy and massage are very important in the treatment of mental diseases.

Tube feeding is sometimes necessary. In depressant cases where the patient refuses to eat, sometimes the sight of the tube will be all that is required for desired effect, or sometimes one feeding is sufficient for the patient to give in. Milk or concentrated foods are used.

Interstitials are necessary in the cases of dehydrated patients.

In some mental cases patients are given a sedative of veronal, from twenty to thirty grains a day for three days, then discontinue; but the patient must be watched closely for drooling at the mouth, etc. Magnesium sulphate is given daily to avoid accumulation of the drug. In some cases chloral, one drachm, is given, but for only one dose, unless a special order is issued by the doctor in charge.

In arteriosclerotic cases the patient is to be kept warm and have proper bowel elimination.

Senile cases admitted to general hospitals are frequently very noisy, are annoying to other patients, also elude the vigilance of nurses and wander into other patients' rooms, annoying and terrifying them. At

home these cases are in the habit of rising at all hours and disturbing the household. In senile cases admitted to mental hospitals from homes or even from general hospitals, it has sometimes taken two or three days to get the proper bowel elimination, due to impacted feces. Keep the patients warm and occupied during the day. These are the only cases in which whisky is sometimes prescribed: from two to three ounces, one given as a hot toddy at night and the patient will sleep until morning. Senile patients have been readmitted after two weeks at home in an excited condition, and the same process of elimination has to be done again.

Formerly mental cases, due to venereal disease, were bed patients and not very nice patients at that. Now they are usually in bed two weeks, up and dressed and gradually fade out, sometimes being in bed two weeks only at the last.

For the most violent patients the only thing is to give hyoscine, morphine and caffeine, and it is surprising how much drug a mental case can take. Morphine sulphate, grain one-half, in itself is not effectual.

Then the sex trend: the greatest difficulty is to keep patients out of trouble and prevent illegitimate children being brought into the world. In some cases, with the consent of patient and relatives, sterilisation is done, but as this is not legalised in Ontario there is always danger of a lawsuit. In some health centres sterilisation is being done in a quiet way, parents realising the seriousness of bringing defective children into the world to become state charges.

At the Ontario Hospital at Woodstock, epileptics only are treated; some are classed under other forms of dementia. Some of these patients are nice, some decidedly nasty. Some have violent fits of temper at times and raise disturbances on the wards. If these patients are put in a room with their mattress on the floor and left to themselves they will quieten

down more quickly than if struggled with. These patients are kept at some sort of work if possible, but only the controlled cases are fit to work in laundry or garden. Epilepsy is not curable, but can be controlled. Doors are not locked during the day but are at night. The diet consists of the heavy meal at noon; meat is restricted, vegetables in variety grown on the farm, milk from their own dairy, all substantial food is given but without frills. Epileptics, like all nervous cases, will yield to suggestion, but will never be coerced.

The dementia praecox patients show an improvement for a year or two and then lapse: these cases are incurable. In some cases, to avoid the possibility of pregnancy, with the consent of parents, the patient is sterilised. In time it is hoped that all mental defectives will be sterilised; at present they marry their own kind and reproduce mental defectives, who, of course, become a state charge.

Nurses in charge of mental cases should have tact, patience, a sense of humour, and, above all, plain common sense; be sympathetic but not too much so as that only makes a patient worse. Suggestion is always a good method to follow.

There are two hundred and six patients in the Ontario Hospital at Woodstock, increasing to six hundred with the new buildings this fall, while there are about fourteen hundred patients in London, including some fifty controlled epileptics. There are eighty-four mental hospitals in Ontario, with ten thousand, nine hundred and fifty-nine patients, employing three thousand, five hundred and eighteen attendants. There are five

hundred and seven student nurses; of these some hundred and seventy graduate by affiliating with general hospitals and obtaining their R.N.

There will be more accommodation at Orillia by this fall, making a total of eighteen hundred, with four hundred increase at Woodstock and one hundred at Brockville. Hospitals are increasing their staffs so as to give more individual attention to patients, which is proving beneficial.

The Epileptic Hospital is the only one which demands pay patients. In other hospitals the usual rate is one dollar a day, sometimes less. No patient is ever refused admittance to an Ontario mental hospital if papers are properly made out.

Mental clinics have been established in seven centres in the province, serving forty cities and towns, according to Dr. McGhie. There is a great deal of work now among the juvenile courts: ninety-six per cent. of the children owed their presence before the judge to lack of or faulty home environment. Social agencies are faced with finding a substitute for the home to repair damage done to children under those conditions. At the present time nurses who are graduates of general hospitals and who wish to take post-graduate work in mental training must go to the United States, but we understand it is the intention of the Department of Health to establish a mental training course in the near future. Let us hope within a year or two graduate nurses may take this further training in Canada.

[With acknowledgment, in part, to the Superintendent of one of the Ontario mental hospitals.]

Our readers' attention is drawn to the announcement, "One-Act Play Competition," which appears on page 99.—EDITOR.

Investigation of the Flora of the Lymphatic Glands in Skin Diseases of Unknown Origin

By GEORGE V. BEDFORD, M.D., Lecturer in Dermatology, University of Manitoba, Winnipeg.

Until recently it has been presumed that certain skin diseases are for the most part local infections of the cutaneous surface of the body. During the last few years this belief has changed, and the change is largely due to the fact that studies involving careful examination of the chemistry of the blood and tissues, the secretion of sweat, the involuntary nervous system and the gastro-intestinal tract have replaced much vague speculation "with well-established facts." These well-established facts suggest that cutaneous disorders must be regarded in many cases as merely the local manifestation of general disorders or infections, and the modern view is to consider the inter-relationship between the skin and the various systems as being of great importance. Particularly important is the relationship of the skin to the lymphatic system. The skin and subcutaneous tissues admittedly form a vast lymphatic lake. The lymph-nodes grouped in well-defined areas and easily accessible in the groins and axillæ serve the purpose of filters for the lymphatic area. It is reasonable to suppose that if certain organisms, whether bacteria or fungi, are constantly associated with the skin lesions, their presence may be made known by an examination of the lymphatic glands which drain the territory involved.

The purpose of this investigation was to examine the flora of these glands in some of the cutaneous diseases of obscure or unknown causation which came under our notice. Our interest in this problem was aroused by the apparently intractable nature of psoriasis and similar associated conditions. As is well known, numerous etiological factors have been alleged to be associated with psoriasis, but the cause has not yet been determined.

In 1924, Civatte reported to the Royal Society of Medicine that "A comparison of the histological features of psoriasis and the psoriasiform type of seborrhœic dermatitis, which may closely resemble each other, suggests that the lesions of the former are inflammatory reactions produced in the skin by a blood-borne toxin, while those of the latter are due to an external microbial infection." Barber has said: "Although the actual cause of psoriasis is still unknown, a consideration of the evolution and the course of the disease points to it being due to a micro-organism of low virulence, against which little or no immunity is developed. It would appear that this disease will eventually be shown to be due to infection with a specific organism, perhaps a species of the streptococcal group." He has stated further that the eruption known as keratoderma blennorrhagica, which is a rare complication of gonorrhœal arthritis, resembles psoriasis, both clinically and histologically, and he suggests that psoriasis may be due to an organism closely related to the gonococcus. Within the last few months a paper was published by Ingram on acro-dermatitis perstans (a spreading dermatitis) and its relationship to psoriasis, in which he emphasizes the similarity between these conditions and suggests that they are the result of "a definite staphylococcal dermatitis." This view would hint at a staphylococcal basis for psoriasis.

We have, then, the theories that the disease is due to: (1) a toxin (Civatte); (2) a streptococcal type of organism (Barber); (3) a staphylococcal type of organism (Ingram).

What is the source of the infection? Is it directly on to the skin surface, or is it through some other portal such as the alimentary canal, as sug-

gested by the work of Wachowiak, Schwartz, and others.

The members of this society^① are aware of the work done by Doctors Cadham and Gibson in the study of the lymphatic glands in relation to multiple arthritis. With their work in view, I conceived the idea that the lymph-nodes, draining as they do the great skin area of the body, might throw some light upon a possible bacterial source of some of the mysterious diseases. They have collaborated with me in investigating the flora of the lymphatic glands in twenty cases.

The following summarizes the results:

	No. of cases	Positive culture
Psoriasis	14	14
Seborrhoeic dermatitis..	2	0
Generalised eczema	2	0
Pityriasis rubra pilaris..	1	1
Darier's disease	1	1

In the fourteen cases of psoriasis, from six nodes a diphtheroid organism was isolated, from three a staphylococcus, and from five a diphtheroid together with a staphylococcus. From the nodes from the patient with pityriasis rubra pilaris a diplococcus was cultured, and from the case of Darier's disease a haemolytic staphylococcus was recovered.

There are many diseases, such as lichen planus, dermatitis herpetiformis, pemphigus, lupus erythematosus, erythema multiforme, erythema nodosum, erythema induratum, etc., which we have not so far had an op-

portunity to investigate, but it is our intention, as the opportunity arises, to include these dermatoses in our studies. Obviously an investigation of a far larger number of cases is required before any definite conclusions can be drawn.

As a justifiable application of our findings we have commenced treatment with vaccines prepared from the organisms found. Long periods of observation will be necessary before any significant deductions can be made from work of this kind. The results obtained up to the present are sufficiently favourable, in our opinion, to justify publication of this preliminary report, with a view to stimulating work along the same lines in other centres, so as to carry to a definite conclusion ideas which our experience up to date have proved to be of some value.

Summary

1. Inguinal glands have been excised and investigated in twenty cases of skin diseases of unknown origin.

2. Fourteen cases of psoriasis yielded positive cultures. No organisms were recovered in two cases of seborrhoeic dermatitis and in two cases of generalised eczema. A diplococcus was cultured from the patient with pityriasis rubra pilaris and a haemolytic staphylococcus was found in the case of Darier's disease.

3. Autogenous vaccines are being employed in the treatment of our cases.

^① Winnipeg Medical Society.

THE STRAIGHT JACKET

Today a strange compulsion had me count its narrow stripes,
And then I mused how on the bolt there seemed just inoffensive stuff,
Yet stuff that made this hideous thing confining frenzied limbs,
Woven to triumph over mad men's livid threats;
Fashioned to stand the writhings from immutable desires,
Strained to the uttermost its binding-tapes have seldom failed.
Ah me, small wonder that such record sets high value on its use,
And so what matter it this urge to knife my sickened heart,
Lest I, I too one day become a debtor to its law!

V. V. R.

Laryngeal Diphtheria

By H. B. CUSHING, M.D., Montreal

Diphtheria of the larynx is unfortunately a common affliction among children, and ranks among the most important causes of death at an early age. Every practitioner of medicine is sure to come across a case in his practice sooner or later, and is sure to remember his first case all the rest of his life. Few medical emergencies are more critical or more distressing. Diphtheria in itself is still a very fatal disease, and nearly half the fatal cases are due to involvement of the larynx. Of 100 cases of deaths at the Alexandra Hospital, Montreal, from diphtheritis, 40 per cent. were laryngeal diphtheria. Laryngeal diphtheria is not only a very fatal disease, but it seems worse because it is such a horrible form of death, to gradually choke, and again because almost all the fatal cases are in young, helpless infants, the usual age being from one to two years. It is, then, an emergency for which every physician should be thoroughly prepared, but it is surprising how few are really qualified to deal with it on beginning practice. After all, perhaps emergency is not the right word, for no child dies of diphtheritic croup in a few hours. The average duration of all fatal cases admitted to the Alexandra Hospital has been four days, and one died under two days from the onset of the symptoms.

Symptoms

The symptoms of the disease have been so often and thoroughly described they should be familiar to all. They comprise a characteristic triad of symptoms, viz., croupy cough, loss of voice and stridor. The cough is diagnostic of involvement of the larynx: once heard it is always remembered; it is as ominous as the sound of a rattlesnake. Every medi-

cal student should hear it once and should be taught that it calls for the immediate use of diphtheria antitoxin, unless there is absolute proof that diphtheria is not present. Every case of croup should be considered guilty of diphtheria unless proved innocent. In the early stages a large dose of serum is not necessary, and a hypodermic syringe full of concentrated anti-diphtheritic serum, at a cost of less than \$1.00, is harmless, easy, and an absolute insurance. It is distressing to think how many lives are annually sacrificed for the lack of it.

Progressive hoarseness leading gradually to total loss of voice is the second cardinal symptom, almost never absent in true diphtheric laryngitis. It is most important as showing actual involvement of the vocal cords, and its absence assists greatly in distinguishing cases of retropharyngeal abscess, pressure on the trachea, etc., from diphtheria.

Laryngeal stridor, retraction of the chest-wall, lividity, etc., are late signs and usually only of importance in deciding the necessity of intervention. Other symptoms are of little clinical value; the cervical glands may be enlarged but usually are not, the characteristic fetor of diphtheria is usually absent unless the pharynx is involved, the fever is very variable, sometimes slight but often higher than in ordinary diphtheria if the bronchi or lungs are involved.

Methods of Diagnosis

As to methods of diagnosis in a doubtful case, the most important point is a careful clinical history, particularly of the gradual development of the above symptoms, remembering that while the onset is usually gradual, the course is apt to be paroxysmal, with periodic exacerbations. The history of exposure to in-

fection is naturally of great importance if it can be obtained, but it is astonishing how frequently it is absent; at least 75 per cent. of our cases gave no history of exposure. As to bacteriological methods, especially culture of swab from the throat, the results are notoriously uncertain, especially if the pharynx is not involved, and in a doubtful case the report should never be waited for. Observation of the effect of the action of antitoxin is the safest method of diagnosis, always keeping in mind that the first effect is a local and general reaction, so that in three or four hours there is generally a rise of temperature and increase in all the symptoms. Direct inspection has come to be the most important means of diagnosis and should be used in all modern hospitals. The improvement of the direct laryngoscope has made a view of the larynx of an infant almost as easy as one of the pharynx, and it is as absurd to diagnose laryngeal conditions without it as to attempt to diagnose genito-urinary conditions without a cystoscope.

The essential fact of an infection by the diphtheria bacillus being established, there remains the important question of the extent of the involvement. If the larynx only is involved or the structures below, there is little danger of toxic manifestations, such as myocarditis or post-diphtheric paralysis, as apparently absorption of the toxin from the larynx or trachea is slight. The outlook and to a certain extent the treatment will depend on whether the membrane is confined to the larynx or extends down the trachea. If the latter occurs, the extension is very rapid and the membrane rapidly reaches down to the finer bronchioles. The membrane lining the trachea and bronchial tree is always loosely attached and separates in large casts, tending to obstruct the larynx, intubation and tracheotomy tubes, and to cause broncho-pneumonia. This bronchial involvement is hard to diagnose definitely in the absence of the casts,

but it may always be suspected if the disease has lasted several days, if the fever is high, if there are finer râles in chest, especially if there is a difference in breath sounds between the two lungs, and always when intubation fails to give immediate relief.

Prevention and Treatment

Before speaking of treatment, a word might be said as to prevention. Remembering the terrible danger to a young infant, one need hardly say the occurrence of a case of diphtheria in a house should call for an immediate immunisation by a small dose of serum of all infants exposed. Apart from this, the active immunisation of infants is now on such a sound basis that the occurrence of diphtheria in a child of two years means that either the parents or the family physician have neglected their duty. Every infant, especially if living in a crowded community, should be immunised at six months. Only when this is systematically done throughout the community shall we be able to control diphtheria.

Treatment may be divided into medicinal and operative. As to medicinal treatment, the most important indication is the immediate use of serum, without waiting for a positive diagnosis. Enough should be given at once, at least 5,000 units. Very large doses are not called for unless the disease is very late and the pharynx is involved. Give it intramuscularly, or, if the case is urgent, intravenously, or if unable to carry this out, intraperitoneally. Remember always the exacerbation of symptoms to be expected after three or four hours from the local reaction. The next most important means of carrying the case through until the serum acts is the administration of some opiate, paregoric or codeine being the most suitable.

The advantages of moist air or steam in some form has been much over-rated. It has been used from time immemorial for croup, and various croup kettles and croup tents de-

vised. While the use of steam may be effective in acute bronchitis of children, in actual diphtheria it does more harm than good. The fear and struggling that a steam tent inspires is definitely injurious, and in any case, the indication is to give as much fresh air as possible, not to shut it out. In all modern hospitals for contagious diseases croup kettles and tents have been relegated to oblivion. Hot fomentations to the neck sometimes seems to give temporary relief, if care is taken not to apply them too tightly to interfere with respiratory movement. The use of adrenalin spray has been advocated, but is of very doubtful service.

In most cases the question arises as to whether some form of surgical intervention is required. The only general rule that can be laid down is to postpone intervention as long as possible; better to wait several hours with all preparations made than to hurry on operation. Remember always that all cases not operated on recover, but on the average 25 per cent. of those operated on die. This is an obvious fallacy because all cases that appear in danger of asphyxiation are finally operated on, but it contains a germ of truth. The only points to be considered are whether the patient is in immediate danger of suffocation and whether he is becoming seriously exhausted by efforts at breathing. The question of absorption of toxin and later bad effects need not be considered as there is apparently little absorption from the larynx and trachea, and it is very exceptional for these cases to show later toxic manifestations unless the pharynx is also involved.

As to the choice of operative procedure, unquestionably the modern scientific course is to do a direct laryngoscopy and remove all mucus and loose membrane by suction. By this method an absolute diagnosis can be made and the extent of the involve-

ment seen. There is no danger connected with it: the operator knows what he is doing and is able to remove casts from the trachea in a way that can be accomplished by no other means. The mortality of cases treated in such a way is remarkably low. Any other method is about as scientific as trying to treat gynaecological cases without a local examination. If the laryngeal obstruction cannot be relieved in this manner or if the necessary instruments and skill are not available, the next choice is to do an intubation. In practised hands this is a very satisfactory and simple proceeding. Almost all deleterious effects, such as retained tubes, laryngeal stenosis, etc., are due to bungling manipulation. If there is no traumatism or bleeding at the time of insertion of the tube, i.e., if there is no violence used there is usually no difficulty in removing the tube. One should remember that the larynx is as delicate a structure as the eye and should be treated with as much respect. Whenever intubation is performed, two subsequent emergencies must be kept in mind, viz., blocking the tube by membrane from below and coughing up the tube. In justice to the patient, no intubation case should be left without someone being within call who has sufficient skill to act in these emergencies; if this is not possible to arrange, an intubation should not be performed.

This brings us to the last point, what is the proper proceeding in country practice when the emergency arises? If the physician has not the necessary instruments and training to perform a laryngoscopy and suction or is unable to remain within easy access of the patient, resort must be had to the methods of the last century and a tracheotomy performed. This is a dangerous and disfiguring operation at best, with a high mortality, but is better than letting the child choke to death.

Mothercraft Training Centre

By GRACE G. BAIN, Toronto, Ontario

On February 1st, 1931, the first Mothercraft Training Centre in Canada was opened at 84 Wellesley Street, Toronto, with Miss Helen C. Satchell, of Christchurch, New Zealand, as superintendent.

For a number of years nurses had been watching with keen interest the work of Sir Truby King and his nurses in reducing the infant mortality rate in New Zealand to almost half of what it had been formerly, but it was not until the work was commenced in Toronto that it was fully understood what *Mothercraft* was going to mean to the mothers and babies of not only Toronto but, in time, all Canada. Starting as it did with one and then two mothers and their babies, the work has spread tremendously until at the present time the Centre is always full to its capacity and there are usually a number of mothers and babies anxiously waiting for a vacancy.

The teaching of *Mothercraft* is not confined to the Training Centre only, but an Out Patients' Department has developed very rapidly. A graduate nurse, with her Mothercraft training, is in charge of this branch of the work, going into the homes and teaching and helping the mothers with their many problems, holding clinics in different parts of the city, where the expectant mother and the nursing mother are both taught the technique and importance of breast feeding.

The Training Centre gives a four months' course to graduate nurses of accredited schools of nursing. The course is a great help and value to all branches of the nursing profession, whether the nurse is doing private duty with obstetrical cases or has charge of obstetrical wards in hospital or public health work, with or without bedside care, for the training covers very fully the antenatal care, the technique of breast feeding, the re-establishing of breast milk, the

correct dieting of infants and young children, and the care and feeding of premature infants.

Since its commencement (or a period covering nine months) between ninety and one hundred mothers and babies have received care and training at the Centre. The time they spend there varies from one to six weeks, according to their condition on admission. When there is a keen desire on the part of the mother to breast-feed her baby, no matter what the difficulties may be, no mother has gone home without her baby being fully breast fed. Mothers with inverted nipples which had been considered hopeless have been satisfactorily worked out and the baby entirely on the breast when dismissed.

Twins are no novelty at the Centre: nearly always there is one pair and sometimes two. It has been thought that no mother could breast-feed two babies for any length of time, but with *Mothercraft* to help them their difficulties are overcome and the mothers are able to carry on the nursing period for six months at least. Little Harry and Harold came to the Centre when only two weeks old, partly breast and partly artificially fed. At the end of six weeks they were both fully breast fed, which the mother continued at home for nine months, when she attended the Out-Patients' Department to be taught how to have them correctly weaned.

The babies are admitted to the Centre at all ages, from a few hours old up to one year. As one looks around the bright and airy nursery, with its pretty chintz screens and comfortable wicker bassinets, where the babies lie tucked up in their blankets, one knows that if they could talk they could all tell what *Mothercraft* has done for them. Here is little David, who came in when twelve hours old—a little premature weighing under four pounds. His mother was taught

to express her milk at home, and his father brought it in each day to the Centre. When David had attained the great weight of five pounds and was strong enough to go to the breast his mother came in to feed and care for him, and when he was entirely breast fed he was ready to go home.

Jimmy was a premature baby, operated on at five weeks for pyloric stenosis, had been artificially fed for two weeks previously, but following arrival at the Mothercraft Centre was put back on the breast. Later he became a flourishing breast-fed baby and could be allowed to go home. A pair of healthy, over-fed twin boys had been ruling their mother at home, tiring her out so that she was losing

her milk supply; but after having *Mothercraft* for a few weeks both mother and babies learned to adjust themselves to regularity of feeding and sleeping and returned home happy and contented.

Mothers as well as nurses receive a training that could not be obtained elsewhere than at a Mothercraft Centre, which training will remain with them all their lives.

The slogan of the Mothercraft Society is, "To help the mothers and save the babies." With this thought in our minds we are assured that *Mothercraft* will be taking an important part in helping to reduce the maternal and infantile mortality in Canada.

The Age Factor in the Employment of Business and Professional Women

By M. ETHEL THORNTON, Winnipeg, Man.

From the report of the first International Convention of Professional and Business Women, I find that the problem of the older woman in business was discussed by Miss Lena Madesin Phillips, President of the International Federation of Business and Professional Women, who spoke of the situation in the United States, and is reported as having stated:

"That, while age was no handicap to women in professions, it was a decided handicap to the women in business, where a woman seeking a position was considered old from the ages of thirty-five to forty, and too old to retain a position after the age of fifty. While insurance could be obtained, this was not a solution, as no able person should be retired from work at the age of fifty who still has many years of service to offer commercial and professional life of the community."

A report of an interview published in the American Academy of Political

and Social Science, March, 1931, states:

It is believed the arbitrary age of forty-five will sooner or later be abolished—as age is simply not a matter of years, but is one of *adaptability, personality and capability*. This report assumes it is safe to say that a very large percentage who seek employment are not employable. Many want to choose work, some are discourteous, others are not adaptable. Many do not read, are not up-to-date in their own line; just drifting; frequently ages of forty-seven to fifty-five have neuritis, bad hearts or kidneys going bad; stomachs that require special food; not sick unto death nor in a condition for hospital—but past their prime of production—with minds out of the habit of studying and bodies neglected or abused, and these face the balance of life as they can, taking what they can get.

Brain Power Increases With Age

In an interview, published in one of the magazines, with Frank B. Robinson, Ph.D., Dean of the School of Business and Civic Administration

(Abridged from a paper read at the Second Annual Convention of The Canadian Federation of Business and Professional Women Clubs, Montreal, July 2-4, 1931.)

and Director of the evening sessions of the College of the City of New York, he first asks the question—Does the brain power increase with age? and then replies to his own question—“There is every reason to believe that it should.”

He then presents these very remarkable facts about the mental ability of students from seventeen to seventy. In comparing youth with middle age, he finds there is hardly a subject in their curriculum that the average mature mind does not grasp with equal and even superior understanding.

As an example, he compares two individuals of equal intelligence, one of forty-five and the other of twenty, both in good health and with good habits—both free from hampering worries, and turns them loose on a new subject in which both are interested. He finds immediately that those of age and experience have all the advantage. The individuals between the ages of forty and sixty, who have ceased to hunt the moon, are normally at the height of intelligent judgment. If health, optimism and determination remain, they have a marked strategic advantage over immature youth.

He cites a recent test in a night school with students who work all day. The regular day student's average age was 19.2 years and in the first year's tests averaged 26.6 per cent. Despite the fact that these day students had all the advantage, the more mature night students, with the benefit of practical experience, out-stripped them emphatically—they averaged 80.3 per cent. marks, while the regular day students averaged only 70.5 per cent. This emphasizes the previous statement—that if health, optimism and determination remain, middle age has the advantage over immature youth. And surely anyone of middle age who has finished a fairly good day's work and undertaken a night course on any subject has at least courage and determination.

In a recent survey, a Director of Employment asked this question: As a physician, do you believe in barring men and women from employment on account of age? More than 85 per cent. answered in the negative and that no one should be allowed to discontinue work dependent upon ability to hold down a job and that no one should be rejected solely on account of age. No physician could say arbitrarily anyone was unfit for physical or mental work because of a certain age. It is a far better investment to repair men than machinery. More than 1600 firms in Pennsylvania have lifted the age ban from employment. It would seem that fitness for a position is the key-note of securing and keeping one. The New Republic, June, 1929, gives this example:

An advertisement—put in one of the papers read, “Help Wanted—Female, under forty, some nursing training preferred. intelligently fond of children, to take full charge of five-room apartment for busy woman editor, partial care of two children six and eight, both in school. Private room, \$80.00 per month.” Eighty-six replies were received, thin and thick, clean and messy, pencilled, typed and penned on pink, blue, white, lavender, gray, beige, black bordered and orchid stationery. From that bundle of letters a sharp picture of the middle aged woman who, after years of security and content finds herself among the desperate, semi-skilled, that clog the market. One applicant said: “I know I am older than you want, but I was afraid you would not see me if I mentioned it and I must find a place soon;” the husband was dead, no insurance, plainly unequal to such emergencies as croupy children, clogged sink or marketing on a stormy day. Age not the problem in this case.

Out of the eighty-six applicants, fifty had had their own homes but never had the inclination or capacity to put aside their own problems and concentrate on a wage earning job; others were trained women discarded

because they were too old. Some managers state they do not want to employ those over even forty as they are afraid of becoming an old folks home. They say they want style and young people; the notion also seems to prevail that young people can be hired cheaper, are more adaptable, more amenable and more even tempered.

One firm, afraid of over-loading its organisation with workers who are paid more than their services are actually worth, adopted a plan which has three distinguishing characters: considering individually each older employee to determine the actual working capacity; keeping each in the best physical condition possible under the circumstances; so arranging the work that each is physically able to use the large experience which she had gained during her productive years.

The National Association of Manufacturers maintain that the charge that older workers are discriminated against is grossly exaggerated and in many instances untrue, yet the figures in 1923 show a larger percentage working over forty years of age and under fifty and still a greater increase in 1928—but from that age on a very sad decrease of these employed.

Their summary is as follows:

Percentage of all workers	1923	1928
Over 40 years	31.88	33.74
“ 50 “	14.49	15.03
“ 60 “	4.65	4.92
“ 70 “74	.87

A State Industrial Relations Department has an interesting report:

1. Arbitrary discharge of workers because of age, regardless of fitness, becoming a general policy.

2. Not age, but experience and capacity and willingness to learn, is important in selecting and retaining employees.

3. Success comes to people *after* forty, for seldom does mature judgment arrive before then.

4. Discrimination against older workers—a confession of inefficient, unwholesome and poor management.

5. Men and women over forty are doing the most important work of the world.

6. Older employees exercise a steadying and helpful influence upon younger employees.

7. Monotonous clerical work is suited to the placidity of middle-aged women.

8. Older women workers are not more troubled by illness than younger women.

I sincerely regret with the very short notice received to prepare any remarks on this important subject I was only able to secure data and statistics of some previous years, but I was able to get an expression of opinion from a member of our Winnipeg club, who is in the position of selecting employees for a large departmental store in our city. With such experience, covering over a number of years, she has forwarded me the following information:

Present conditions are affecting two classes very much in excess of others, namely, those just out of school with little or no experience, and those older women both with and without experience. Dealing with the first group—from the standpoint of office and general business—the closing of many offices (brokerage and grain as well as others through failure and amalgamation) has given firms wanting office help the opportunity to secure those with experience to fill their vacancies. There is not sufficient demand to place all of these experienced people, so that even junior positions are accepted by those qualified for better positions due to financial stress. This condition leaves the students just through with their course with little hope of work. Reduction of staff due to lack of business is also a cause for this condition, as even temporary work is taken by those who have been laid off. Older women with experience have, in many cases, worked up to a position unique with the firm employing them, then in a depression like this they find themselves without work and their previous experience of

little or no help in securing further employment.

Today the trend of our times has brought younger men to the fore in positions of responsibility (the war of course played its part here). These men find it more satisfactory to have women younger than themselves working for them. This is to the disadvantage of the older woman. Older women trained and experienced, i.e.: the teaching profession, who either are forced or wish to change to another occupation after perhaps thirty-five or forty years of age, find it rather hopeless unless they are outstandingly clever in some line and can secure a foot-hold in order to prove their worth. Such changes are almost out of the question today.

There is no doubt that the industrial individual of forty-five years of age and over, under present industrial conditions, is up against a very hard proposition. When business conditions are anywhere near normal chances for securing employment are fairly good, providing of course, one is physically fit, but chances for securing work especially in subnormal times are only possible, or at least very much better, if one has special training. Statistics prove that a woman of forty or fifty is a better workman than a younger one; more dependable and comes more nearly maintaining the average production than younger blood. Loyalty to a firm gets a sad set-back when the age question is brought in, for who can be loyal to any firm with a policy that classes a woman as undesirable when physically and mentally sound? Do we still cling to the "Camel" theory of education? By drinking deeply at the fountain of knowledge in school and college do we consider ourselves stocked up for life, or having learned a business or profession do we think we can coast? If so, then these are the people who never rise above mediocrity and frequently have no position after forty. Almost without exception, those who have achieved success in

industrial life or in the arts and sciences are more eager and effective students at forty-five and fifty than in the old school days. On the other hand, many with plenty of promise wither on the branch of middle age because they follow the camel theory; some are victims of the general delusion that after thirty-five and forty the mind is not capable of grasping new subjects with the clearness of youth. It is for the want of mental curiosity, attention, careful and comprehensive judgment, sound moral purpose, that most fail to develop during adult life in their mental powers. Many minds not only make vast acquisitions but also experience a large unfolding of mental capacities during the period of middle life. If the mature fail to keep pace with youth, it is usually due less to lack of power than to weakness of will, the propensity to settle back in a rut, to let hampering responsibilities dull initiative and to slack up in carrying out a vision.

It seems imperative also that it should be brought home to the younger groups that notwithstanding the good times and fun, they cannot expect society to take care of them if health is ruined, mental training neglected, and they fail to appreciate their responsibilities for the future.

Too much cannot be said about the need for personal development—for some conception of a way to get along socially. A great many failures are due to personal peculiarities, rather than a lack of knowledge.

With the foregoing opinions of those in positions of authority and the statistics quoted from surveys made, just what are we to do in middle life or the peppermint years, as some one has so aptly expressed it?

I think we might have at least three very definite conclusions:

First—To keep physically fit.

Second—To keep mentally fit.

Third—To provide for our declining years by some means of insurance or savings.

Canadian Nurses Association Tentative Programme, Biennial Meeting

SAINT JOHN, NEW BRUNSWICK, JUNE 21-25, 1932

MONDAY, JUNE 20TH

2 p.m. Meeting of Executive Committee.

TUESDAY, JUNE 21ST

9.30-12.00 GENERAL BUSINESS.
Reports of Standing Committees.

2.00- 4.30 PRESIDENTIAL ADDRESS.
Reports of Special Committees.
Reports of Provincial Associations.

EVENING ADDRESSES OF WELCOME.
ADDRESS: "The Public and the Survey Report."—The Hon.
Vincent Massey, LL.D.

WEDNESDAY, JUNE 22ND

9.30-12.00 GENERAL SESSION—A Consideration of Selected Recommendations
of the Survey Report.

General Topic: "The Approved Training School."

9.30-9.50 Introduced by Miss E. Kathleen Russell, Director, Department
of Public Health Nursing, University of Toronto, and Nurse
Member of the Joint Study Committee, Survey of Nursing
Education in Canada.

Sub-Topics:

9.50-10.00 (a) "The Superintendent and Staff Nurse, the Instructors,
Nursing and Medical"—Miss M. K. Holt, Superintendent
of School for Nurses, Montreal General Hospital.

10.00-10.10 (b) "The Entrance Requirements"—Rev. Mother Ignatius,
Superintendent of School for Nurses, Antigonish, N.S.

10.10-10.20 (c) "Number of Beds, the Curriculum, Supervision and In-
spection"—Miss G. L. Rowan, Superintendent, Grace
Hospital, Toronto, Ont.

10.20-10.30 (d) "Registration Acts"—Miss E. MacP. Dickson, Super-
intendent of School for Nurses, Toronto Hospital for
Consumptives, Weston, Ont.

10.30-12.00 General Discussion—Concluded by a general summary and the
presentation of related resolutions by Miss E. K. Russell.

2.00- 4.30 GENERAL SESSION—A Consideration of Selected Recommenda-
tions of the Survey Report.

General Topic: "The Cost Analysis of Nursing Education."

2.00- 2.20 Introduced by Miss Jean I. Gunn, Superintendent of School for
Nurses, Toronto General Hospital, Toronto, and Nurse
Member of Joint Study Committee, Survey of Nursing
Education in Canada.

Sub-Topics:

2.20- 2.30 (a) "The Cost of the Student Nurse to the Hospital"—Miss
M. McKee, Superintendent, General Hospital, Brant-
ford, Ont.

2.30- 2.40 (b) "The Comparative Cost of Student and Graduate Nurse"
—Miss G. Fairley, Superintendent of School for Nurses
General Hospital, Vancouver, B.C.

- 2.40- 2.50 (c) "The Budget System"—Miss H. S. Buck, Superintendent, Sherbrooke Hospital, Sherbrooke, Que.
- 2.50- 3.00 (d) "Financial Aid from Government for Nursing Education"—Miss R. Simpson, Director of Public Health Nursing, Provincial Department of Health, Regina, Sask.
- 3.00- 4.30 General Discussion—Concluded by a general summary and the presentation of related resolutions by Miss Jean I. Gunn.

EVENING

7.00 P.M.

DINNER.

ADDRESS: "The Scientist and the Survey Report"—Professor Roy Fraser, Mount Allison University, New Brunswick.

THURSDAY, JUNE 23RD

- 9.30-12.00 THE CANADIAN NURSE.—A discussion of related reports and other business.

NEW BUSINESS.

- 2.00- 4.00 SECTION MEETINGS:
Nursing Education.
Private Duty.
Public Health.

- 4.00 P.M. Hospitality tendered by New Brunswick Nurses.

FRIDAY, JUNE 24TH

- 9.30-12.00 SECTION MEETINGS:
Nursing Education.
Private Duty.
Public Health.

- 2.00- 4.30 GENERAL SESSION—A consideration of selected recommendations of the Survey Report.

General Topic: "The Distribution of Nursing Service."

- 2.00- 2.20 Introduced by Miss Jean E. Browne, Director of Junior Red Cross for Canada, and Nurse Member of Joint Study Committee, Survey of Nursing Education in Canada.

Sub-Topics:

- 2.20- 2.35 (a) "Supply and Demand"—:

"1. The Unemployment of Nurses.

"2. The Reduction of Supply of Nurses.

"3. Increase in Demand for Nurses."

Miss K. Ellis, Superintendent of School for Nurses, General Hospital, Winnipeg, Man.

- 2.35- 2.45 (b) "Socialised Nursing"—Miss E. K. Connor, Director of Health Education, Normal School, Edmonton, Alta.

- 2.45- 2.55 (c) "Dominion Bureau of Nursing"—Miss A. J. MacMaster, Superintendent of School for Nurses, Moncton, N.B.

- 2.55- 4.30 General Discussion—Concluded by a general summary and the presentation of related resolutions by Miss Jean E. Browne.

EVENING

ADDRESSES:

- (1) "The Medical Profession and the Survey Report"—Dr. G. Stewart Cameron, Chairman, Joint Study Committee, Survey of Nursing Education in Canada.

- (2) "The Educationist and the Survey Report"—Professor F. Clarke, McGill University, Montreal.

SATURDAY, JUNE 25TH

- 9.30-12.00 REPORTS OF SECTIONS—Activities throughout the year and findings of the sessions.

Report of Resolutions Committee.

Election of Officers.

- 2.00- 4.00 Meeting of Executive Committee.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,

Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

Arranging a Teaching Schedule in a School for Nurses with only One Instructor

By EDITH G. YOUNG, Instructor of Nurses, Nicholls Hospital, Peterborough, Ontario

At the outset, one must realise that while there are certain definite principles to be complied with in arranging a teaching schedule in a school for nurses, there are also individual problems which require careful study.

In attempting a discussion of this subject, it seemed to me that a resumé of the methods employed in one definite situation might prove of greater interest than a general survey of various programmes. Therefore I shall attempt to explain the system used in our school.

As I was the first full-time instructor in the school, averaging from thirty to forty students, my programme necessarily passed through many stages of experimentation before it finally evolved as a feasible and practical schedule which would meet the needs of our school and hospital.

In planning lecture hours, there is much to be considered in order not to interfere with the efficient and smooth running of the various departments: the wards must not be depleted during busy hours, such as the morning and evening toilet of patients, doctors' rounds, meal hours, etc. Then, too, the hour assigned for lectures must not conflict with the lecturer's office hours. Evening classes are not permitted except when

it is impossible to secure the services of the lecturer during the day. When it can be arranged, lecture hours are given outside of recreation hours.

The preliminary class, consisting of from ten to sixteen students, is received twice during the year—September and March. The term is of four months' duration.

During the first month, the students spend all their time in the classroom, with the exception of a general survey of the various departments of the hospital and follow-up work in the practice of the most elementary nursing procedures, such as dusting, bed-making, carrying of trays, care of bathrooms, etc. They are not scheduled in any department for any specified time. The class periods begin at 8 a.m. and end at 4.30 p.m., ten minutes' recreation between each period, with one and a half hours for lunch, making in all a six-hour day. At least one hour of this time is allotted to study or practice. As this first month is necessarily one of readjustment for the students, I have found it necessary to introduce new material very slowly and make frequent repetitions.

During the second and third months, the students are definitely scheduled for duty in the medical public wards—from 7-9 a.m. and 4-7

p.m. They have a half day on Saturday and four hours on Sunday. In the intermediary period between 9 a.m. and 4 p.m. they have four hours theory and demonstration. Whenever possible the students are taken on the wards for practise in the various procedures immediately following the practical demonstration. No student is allowed to carry out any procedure on the ward for the first time without supervision of the instructor or graduate ward supervisor.

During the fourth month they have one hour class daily and two hours' recreation; the remainder of the time on ward duty. Two weeks is the usual period assigned for each student in the various departments—medical, surgical, dressing-room, diet kitchen. During this month they have entire responsibility for two convalescent patients, including charting, and special attention is given to observation of their ability to give practical application to their earlier instruction.

The supervisor in each department presents a written record of each student at the end of her term of service.

I arrange the preliminary schedule so that I may be free to be in attendance at all other classes if possible.

In the junior term the spring section of the class receives three hours' lecture weekly from the instructor in the period between September 15th and June 1st; the fall session, one hour daily from December until June. Thus at the end of the term each section, in addition, has covered the curriculum for that year. The doctors' lectures for the junior year are given in the afternoon from 4-5 p.m. or 5-6 p.m. These do not begin until November. Both sections attend the lectures. In the second year, an average of 4-5 hours and in the third year 3-4 hours' lectures are given weekly.

At the beginning of the academic term, September the first, a schedule of lectures is prepared under the following headings:

Subject	Number of Lectures	Hour	Day	Dates	Lecturer
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The arrangement of subjects is fixed as far as possible with the subjects in proper sequence and with relation to ward assignments. As the lectures are not repeated during the term, it is necessary for the entire class to attend, and considerable attention has to be given to the assignment of students in the various services. The schedule is then submitted to the various lecturers, who almost without exception are willing to co-operate. As far as possible the lecturers are given the same day and same hour each year for their lectures. Each lecturer is allotted two extra periods, as occasionally his practice demands his service at class periods. In this way, there is no overlapping of the schedule.

The total number of lecture hours during the three years is 625.

The school has a small library to which students have access at definite hours. Students are encouraged to do as much reference reading as their time permits.

So far it has not been possible to arrange any definite social or athletic activities, but it is hoped that in the near future this may form part of our programme.

One of the greatest problems in the small school is that of attempting to instruct in the same class students with various degrees of preliminary education, ranging from the minimum of two years high school to those with normal training.

In reviewing the general scheme of instruction in the smaller schools, it might seem at a glance that to be deprived of association with the higher institutions of learning, with their more systematic scheme of organisation, is much to be deplored, but, on the other hand, one must realise that the majority of the students in smaller schools are derived from the community and adjacent districts and therefore understand its modes, its customs and institutions, and are in a position to fulfill very satisfactorily the specific needs of their own community.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,

Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

Lobar Pneumonia

By EVELYN McTAVISH, McKellar General Hospital, Fort William, Ont.

Lobar pneumonia is an acute, infectious disease due to the pneumococcus, characterized by inflammation of a lobe or lobes of the lung, toxemia and fever. Of the acute fevers it is one of the most common and the most fatal of all. The pneumococcus is a typical diplococcus; it is encapsulated, non-motile, and does not form spores. The capsule is well-developed in virulent strains and may be scant or absent in less virulent types, therefore it is believed that the capsule is a means of protection for the organism and may be an index of virulence of the strain. The pneumococcus is differentiated into four definite types. The usual case seen belongs to types 1 and 2. Type 3 organism causes the highest percentage of mortality and has the best developed capsule of all, while type 4 has a poorly developed capsule and is the causative agent in the mildest cases of pneumonia. Also it is the variety found in buccal secretions of normal individuals. The pneumococcus forms an endotoxin, i.e., a toxin within the organism, and this toxin is liberated on disintegration of the organism, producing the toxemia found in pneumonia.

Pneumonia occurs most frequently in winter and early spring. The disease occurs at all ages, but is greatest between twelve and thirty-five years and is about twice as common in the male as the female, due to environmental conditions and to different degrees of exposure; the aged and alcoholics are also prone. Bad ventilation, dark rooms and over-crowding increase the incidence of the disease,

while lowered resistance by such diseases as diabetes, erysipelas, nephritis and typhoid are also predisposing causes.

The pathological processes are divided into a stage of engorgement, red hepatization, gray hepatization and resolution. These changes develop in a continuous sequence and are not distinct or different processes. In the stage of engorgement the pulmonary capillaries become very congested, the alveolar epithelium is swollen and some blood plasma enters into the alveolar spaces. This stage lasts only a few hours before red hepatization begins. In this stage the air cells become filled with an inflammatory exudate rich in fibrin and red blood cells. On cross section the lobe of the lung looks red, is very solid and heavy and has the appearance of liver. In the third stage the red cells disintegrate and their place is taken by leucocytes which migrate from the capillaries into the alveoli and on cross-section the lung is grayish in colour. The fourth stage, or resolution, begins after the crisis. The leucocytes disintegrate and in doing so a ferment is liberated which acts on the blood clot and liquefies it. Most of the liquefied exudate is absorbed by the blood stream and eliminated by the kidneys. A very small amount is expectorated.

The real danger in pneumonia is not from plugging of the alveoli by the exudate, nor from the germs directly, but from the toxin of these germs. It is this toxin which produces the toxemia and accounts for the fever, increase in pulse and respiration,

dyspnoea, etc. The fact that one or two lobes may be involved does not account for these symptoms, for it is a well-known fact that tuberculous individuals with one lung collapsed and not functioning do not have them.

Little is known of the incubation period, but it is probably very short. The onset is usually sudden, beginning with a severe chill lasting from one-half to one hour. The chill subsides and a sensation of unbearable heat comes on. The skin and mucous membranes, which were pale during the rigor, become flushed and red. Throbbing headache, torpor or delirium may appear. The temperature rises to 104° or 105° F., and vomiting is frequent. Intense pain in the axillary region is often present, due to an accompanying pleurisy. The cough at first is dry, hacking, frequent and painful, but later, during the stage of red hepatization, becomes productive. The expectoration is blood-stained and is known as rusty sputum, due to its appearance. It is very tenacious and sticks to the lips. Later, if the sputum becomes prune-coloured, it is a bad sign, suggesting the breaking down of lung tissue.

On the second or third day the typical picture in pneumonia is presented. The patient lies flat in bed or on the affected side, the face is flushed, sometimes unilaterally, the breathing rapid and difficult and often accompanied by a short, expiratory grunt. The eyes are bright, the look anxious, and the nostrils dilate with each inspiration. The tongue is coated and herpes may appear around the mouth or nose. The temperature is still 103° to 105° F., and there is very little daily variation. The pulse is rapid, full and bounding. Cyanosis may be present, but is not usually until later, when the heart may become affected. Constipation is usual and the urine is highly coloured, frequently containing albumin and casts. A blood count shows a leucocytosis, a high count indicating a favourable prognosis. The polymorphonuclear leucocytes comprise 90% to 95% of all the white cells, while normally they comprise

72%. A positive blood culture is often obtained.

The crisis may occur any time from the third to the tenth day. The temperature suddenly falls and may reach normal in twelve hours. If it drops to normal within twenty-four hours it is known as a protracted crisis. If longer, it is known as lysis. The patient seems for a time to be getting worse but then improves. Beads of perspiration appear on the face and then cover the whole body. Respiration is easier, slower and less laboured. Cough is less, cyanosis disappears and the patient passes from a state of extreme illness to one of comparative well-being. In very severe cases the crisis fails to develop. Dyspnoea and cyanosis increase. The temperature continues high, the pulse becomes more rapid and weaker. The patient becomes comatose and, often, dies.

After the crisis the consolidated lung usually resolves rapidly but sometimes may take as long as six weeks and is then known as delayed resolution.

Complications are empyema, pericarditis, endocarditis, arthritis, lung abscess (infrequently in lobar pneumonia), also meningitis and otitis media, especially in children.

Good nursing care is extremely important in all cases of pneumonia. The patient should be put to bed in a bright, quiet, well ventilated room if possible. Drafts should be avoided. Absolute rest is essential. He should not be allowed to feed or wash himself or to exert himself in any way, as increased strain on the heart may lessen his chances of recovery. Visitors should be limited. Frequent cleansing of the mouth, nose and lips is necessary, also the application of a lubricant. Fever should be treated by the use of tepid water or alcohol sponges. Temperature, pulse and respiration should be taken and charted every four hours. Note should be made of amount of rest, dyspnoea, amount and character of the sputum, amount of fluid intake, etc., as well as any untoward symptoms such as cyanosis, weakening and irregularity of the pulse, distention

of the abdomen, and should be reported immediately to the doctor in charge of the case. The bowels should be kept open by the use of enemata. Dyspnoea can sometimes be alleviated by elevation of the head and shoulders on pillows. Headache will be lessened by the application of an ice cap.

Proper nourishment is of considerable importance. Milk should form the basis of the diet, with an abundance of water, fruit drinks such as orange, lemon and grape juice; broths, gruel and egg in the form of egg-nog, albuminized broth or fruit drinks. Soda water or lime water added to fruit or milk drinks will at times overcome a tendency to nausea. Carbohydrates should be used sparingly, due to the danger of producing tympanites. If tympanites develops, feedings should be stopped for a few hours so that the beneficial effects of stupes and other remedial measures may be attained. Sugar and milk (unless peptonized) are better left out of the diet for a time when feedings are resumed. Feedings should be of from four to eight ounces at two-hourly intervals during the day and four to six hours during the night, with water and fruit drinks ad lib between feedings. As the acute symptoms subside the diet should be gradually increased, first with custards, jellies, junket, soft-cooked egg, etc. Meat

should not be included until convalescence is well-established.

Specific treatment is ordered by the physician. Pain is relieved by the application of heat or cold. Diathermy is frequently used in hospital cases. Digitalis is usually given. Brandy is often used as a stimulant, while strychnine, camphor-in-oil, or caffeine sodium-benzoate are given when rapid, transient stimulation is desired. For frequent, unproductive cough, codeine or potassium citrate is sometimes used. Abdominal distention is treated by enemata, turpentine stupes, inserting rectal catheter, pituitrin or physostigmine. At the present time only types 1 and 2 are treated by the use of serums.

During convalescence an abundance of fresh air and sunshine, rest and nourishing food are essential.

Preventive treatment consists in proper disposal of buccal secretions, linen, etc. Spray from the mouth in coughing or sneezing is infective four to five feet away from the patient. Avoidance of exposure when over-fatigued and also over-crowding should be avoided. It was found in the Panama Canal Zone that placing men in huts in small numbers rather than closely together in bunks decreased the number affected with the disease. Vaccine has been found of value as a preventive, but its use is not general as yet.

It takes ten thousand kilos of rose petals to make one kilo of attar of roses. Which reminds us that not only for this rare perfume does it take much to make little, but if the fragrance of living is to endure, ten thousand kilos of idealism will make but one kilo of human progress. We need to remember this when the steel of our good courage tends to lose its temper.

JOHN C. WINGELL.

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Trends in Health Education in Elementary Schools

By RAE CHITTICK, B.Sc., Reg.N., Instructor, Provincial Normal School, Calgary, Alta.

Probably no other subject on the school curriculum has gone through a more rapid metamorphosis in the last few years than that of health education. The rebirth of health education came following the world war, partly because of the enormous number of physical defects discovered through military examinations; partly due to health impairment, especially that of children in war ravished districts; also because of war-time organisations turning their attention from caring for the sick to prevention of illness and public health problems.

In its previous existence, hygiene and health had disgraced itself—becoming a dark, fearsome subject that talked of multitudinous bones, auricles and ventricles, and the degenerative effects of alcohol and tobacco. It is no wonder that to teachers and pupils it became a tedious affair, which was gladly thrown into the discard for something more cheerful.

Its revival came with a somewhat overwhelming rush—health became popular. It was urged on by insurance companies, soap manufacturers, cereal companies and canning concerns. With so much attention focused on health, it again returned to the schools. This time it appeared no longer under the name which implied so much distaste, but under a newer title, Health Education. Remembering its disfavour in former years, educators were determined that it should not be a dry-as-dust textbook subject recounting facts of physiology and horrors of disease. It must come alive and be made to function in the

lives of the children. In the great effort to accomplish this, to make it interesting and avoid the pitfalls of former years, it took on a sort of jazz movement. Stories and rhymes and dramatisations embellished the presentation; three-headed monsters, funny goohoolies, dwarfs, fairies, and grimyjoes took on responsibilities for children's health. Children became cannibals and ate Fanny Fat, Patrick Protein and Minnie Mineral Water. This treatment of the subject had its good points—posters, pictures and charts did arouse some enthusiasm—stories did break the monotony, no matter how unscientific they were.

Yet after all it was poor pedagogy. If a subject is intrinsically interesting it should not have to be made interesting. Why then did it need such ornamentation to create enthusiasm? In its earlier form, one of the reasons given for the failure of hygiene was the overloading of scientific material. It was then assumed that if children knew the reasons for certain things, habits would naturally follow. This assumption proved erroneous. Now, with its rebirth, the trend was away from reasons—try to develop the habit without explaining why—make it seem the thing to do, because brownies or fairies say so. Many a pedagogical crime has been committed in this great effort to put health over in this "interesting" fashion.

The story is told of a little girl who was taught that magic elves worked in her mouth and in her stomach, and when she ate her meals these little people set to work and did wonderful things to digest her food. Therefore,

she must be careful not to overwork these magic helpers. The sensitive child spent hours in front of a mirror, peering under her tongue and around her teeth in a desperate attempt to catch sight of one of the workers. She worried over the things she ate, and a fear grew on her of these strange people working away so secretly. The child developed a nervous condition that kept her out of school for several weeks. This, of course, seems extreme. Fortunately, most children promptly forget all about these willing workers who are supposed to inhabit their bodies, and of the fairies who take such a kindly interest in their health habits.

Added to this type of health teaching came drives for one hundred per cent. correction of physical defects, which developed into blue ribbon and gold star competitive campaigns. Such pressure brought to bear on the child led to hyperconsciousness of health, so that this new health education programme seemed headed for rocks sharper and more dangerous than those that ended the life of physiology and hygiene. Fortunately, however, health education seems to be developing a saner course, and an ignominious retreat from the curriculum has been prevented.

There first came the idea of correlation, making health a part of the other subjects on the course of study—history, geography, science, etc. This was a step in the right direction, although with this movement came many far-fetched correlations of a fantastic character. Health education was wedged in wherever possible, or the teacher made a valiant effort to teach art or English or history along with her health instruction, in order to make the best use of the time and also to overcome the danger of making the child health conscious. Following this correlation movement comes the more modern trend of dropping subject matter divisions and grouping work around topics or units of study. With this tendency health education is taking a natural, right-

ful place, needing no embellishments to put it across or other subjects attached to make it more worthwhile. The unit system seems to have proven its worth and is probably here to stay. The breaking of trends of thought and the pigeon-holing of children's interests into subject matter fragments by time-table divisions seem to be going into the discard.

Units of study mean different things to different people, and all types of units do not lend themselves to health instruction. I cannot go into the construction of units of study here, but if the reader is interested would refer her to an excellent bulletin on this topic published by the State Superintendent of Public Instruction, Pierre, South Dakota.

Two types of units, however, I should like to mention:

(1) A unit centred around a worthwhile, purposeful project and allowed to develop into whatever subject matter it will. The project might be to study how the Panama Canal was built, and in such an undertaking would come a wealth of material on science, history, geography, and community health. It might be to decide how a hot lunch could be served in the school at noon. With it would come composition in the form of letters to parents and school board, arithmetic in computing the cost, drawing in designing a cupboard, lessons in food values, etc. It might be to undertake the equipment of the school yard with suitable play materials; or the study of the life of the Eskimos, with emphasis on the adjustment they have made to their environment regarding homes, clothing, food, industries, etc. This type of unit works out exceptionally well in ungraded schools, as each class undertakes some part of the study which most interests that particular age level, and the whole is assembled to make a completed project.

(2) The Theme or Generalisation Unit: In this type of unit the teacher chooses a pivotal issue, the understanding of which would be most

valuable for the individual and society. The theme, "Man is constantly increasing his control over his environment to improve his living conditions," could be admirably developed through a study of pioneer life in relation to modern life. Here in Alberta, under our present course of study, such a unit could be very well developed in grade V, where they make a study of the exploration and settlement of the North-West. So many vital health problems come up in such a study—the food problem: salting, drying and preserving foods compared to modern methods of canning; making bread today compared to pioneer methods; advantages and disadvantages of modern milling of grains; danger of scurvy in pioneer days, danger of over-refinement at present; the housing problem: small, crowded homes; windows of oiled paper; difficulties in heating and ventilation; the care of the sick; few doctors and practically no skilled attendants; the development of household remedies and certain superstitions; high infant mortality rate, etc.

Such units integrate health with the other work of the school day. They form an intrinsic part of the topic itself and a very worthwhile part. Children see their exact relation and there is no enforcement of related facts. This does not mean, of course, that health is not taught outside a unit. Problems for direct health teaching arise in the school room every day, and these opportunities must not be lost. The great obstacle now to such teaching is the rigidity of our present courses of study, which does not allow teachers to consider pupil interests, but definitely states that certain material must be covered in each grade.

I seem to have saved the most important type of health instruction to mention last. Possibly, the best type of health teaching comes through the creation of the proper environment: an environment where health comes as a matter of course, where actual formal health instruction is almost

superfluous. If a child has an opportunity to live healthfully through the school day, seldom does he need formal instruction. If there is a clean basin and warm water, soap and towels, he usually likes to wash his hands. If the toilet is comfortable he goes regularly. If his seat is adjusted properly he tends to sit straight. Then the teacher asks, "What about his home habits?" And here comes formal instruction in an attempt to educate the parents through the child. This is a questionable procedure, yet one knows not where to begin as these children are the parents of the future. One begins to wonder how much transfer there will be from formal health instruction at school to the homes of the future. Possibly it remains to be seen. Yet I think the criticism still holds good: there is too much preaching on health habits and not sufficient time and thought placed on the creating of a favourable environment, which the child accepts as a matter of course. As Wm. McDougall states in his book, "Character and Conduct of Life," "In order that children shall practice virtuous habits it is not necessary to name these virtues, nor denounce the opposites."

Summing up the trends in modern health education, I should say, then, that there are three important movements:

(1) Less stress on the formal teaching of health habits and more on creating a favourable environment where the child has an opportunity to live healthfully throughout the school day.

(2) Teaching focused around a project or pivotal theme, with the integration of all subjects, including health.

(3) The tendency to have children face facts, giving them scientific reasons to the utmost of their understanding in an effort to develop a critical attitude toward information. Overstreet has so well stated it, "Not so much a knowledge of facts as an attitude toward facts—an attitude which refuses all substitutes."

Excerpts from News Letter, December, 1931, Department of Public Health Nursing, Manitoba

DAUPHIN.—“I attended a meeting of the School Board with a request that general vaccination throughout the schools be proceeded with. It is five years since this was done, and the result is that the first five grades at the present time are mostly unvaccinated. The School Board endorsed the proposal to have the children vaccinated, but could not afford to have vaccination done at their expense.

“It has therefore been arranged by the health officer to vaccinate all children whose parents desire it at a charge of fifty cents, on a special day, at the Child Welfare Station.

“A very appreciative letter from the Executive of the North-Western Teachers' Association has been received regarding the assistance given by the public health nurse at their convention.”

ETHELBERT.—“On arriving here I settled the question of conveyance by renting a horse and buggy from the hospital, and started forth wondering just how I was going to get along. Not being previously acquainted with a horse I felt rather dubious of the drive. However, even though Teddy (the horse) proved very modern and rather flighty at times, we kept to the road, and I gradually realised which side one should drive from. Before the week was out I found that I could turn around in a little less space than a five-acre field!”

NORWOOD.—“Since October, 1930, the public school teachers have contributed a portion of their salary each month, and have given it to the public health nurse to use for social service work as she thought best. In all, to date, they have given seventy-two dollars and twelve cents (\$72.12). By this means food, clothing, dental care, school books for needy children have been given, and some attention also to children in hospital. This practical help from the teachers has been much

appreciated and enabled the nurse to give help where otherwise she would not have been able to do so.”

“At Morden School I found no washing facilities. I interviewed the chairman of the School Board, who visited the school next morning and gave instruction to the janitor to provide basins, paper towels and soap—one for boys and one for girls, also one for the teachers. This splendid co-operation was greatly appreciated.

“The Board of Trade, Morden, have been trying to procure a room for a Child Welfare Station, but so far without success. Going through the school at Morden I found the library room not in use, and immediately thought of the Welfare Station. I lost no time in interviewing the chairman of the School Board and explaining my mission. He said it would be taken up at the next meeting next week. Then I interviewed each member of the board. At the meeting held the following week, it was decided to allow the library to be used for a Child Welfare Station.”

WOODLANDS. — “‘The Manitoba Child’ is greatly appreciated by mothers in the district; in fact, many of them had written to the department asking for the book before I visited the remote parts of the community this spring.

“I used ‘The Manitoba Child’ as a text book in giving a group of ‘teen-age girls instruction in the care of a pre-school child, so that they may qualify for the Girl Guides’ ‘Child Nurse Pin.’”

“Excellent publicity in health work has been given by Miss — in the various stores of St. Vital by means of a window display to promote interest in diphtheria immunisation.

“Miss — obtained a poster set-up from headquarters, and used small posters (that were made in the schools) to add to the local interest.”

SHELL RIVER.—“Last June there was on the list of absentees from ——— School, the name of a child who seldom stays away, so I visited him at home. He was ill, complaining of a slight sore throat. There was a small, white patch on one tonsil, and he had some temperature. It looked like tonsillitis, and he had had diphtheria four years ago; but I took a swab, and reported to the health officer. The report on the swab was positive for diphtheria. That same week the Child Study Group had a meeting, the topic for discussion being “The Sick Child,” and I was to lead the discussion. The outline for this discussion dealt mainly with contagious diseases, so it seemed the ideal time to discuss toxoid. We did, quite thoroughly, and ended in a decision to try and have a toxoid clinic in ———. I consulted the health officer the next day, and he, of course, was only too glad to give his co-operation. Then in the classrooms at school I explained what we were trying to do and why. After a conversation with a mother of a grade II child, as ‘Will you please put my children’s names on the list for toxoid? I really do not want them to have it now, as they had serum for scarlet fever last fall, but my oldest girl insists,’ I decided I had some real promoters for the clinic in the lower grades. We hoped to have fifty children at the clinic, but we had one hundred and sixty-five children and adults treated. The child who had diphtheria seems quite all right (we found he was sitting beside a carrier at school), and we have no new cases, and there will be a number of children immune in a short time. Last but not least it may stir up the councillors, so that we can get all the children done in the fall. At present they do not want the extra expense.

“The teachers and pupils of ——— School have a visitors’ day once a month, when they entertain with a short programme, and the teacher asked me to visit the school and stay

for the programme for this occasion. At three o’clock the visitors arrived —nearly all the women in the district came; some walked three miles. The programme which the children gave was very enjoyable. Most of the items were on health, and I gave a short paper on ‘The Pre-school Child’ to the mothers. As there is no women’s organisation in this district, they seem to appreciate this opportunity to discuss their work and plans while they enjoy a cup of tea at the end of the programme. This seems to me to be an idea which could be worked out in most rural schools. It gave me an opportunity of talking to those mothers which I would not have had otherwise. This, I hope, will prove a solution to one of my many problems, which is that of meeting the mothers living in ——— municipality, where I work only two days each month, and that, of course, does not allow time to do any home visiting.”

From British Columbia

Through the efforts of our Nursing Service and through the contacts which we are making in other directions with the local organisations in all parts of the province, we have established the Provincial Board of Health in a very different position to what it was five years ago. We are accepted now as presenting to the public policies that have been demonstrated to such an extent that there is no doubt in the minds of the public of the benefits that will accrue provided they follow out the directions of the Provincial Board and back us up in our endeavour to procure further encouragement from the powers-that-be in the different municipalities and out-lying districts.

Dr. H. E. YOUNG,
Provincial Health Officer for
British Columbia.

Thirty-fifth Report of the
Provincial Board of Health.

*Florence Nightingale—A Review**

Reviewed by MARGARET ISABEL LAWRENCE, Toronto, Ont.

A woman with a lamp in her hand, walking the long walk of the barracks hospital, down one row, up another, along still another—four miles of beds, in the winter nights of the Crimea—this is what stays in the imagination concerning Florence Nightingale. A pitying woman's heart, torn by the suffering of the race, and the added needless torment of war; giving to men who watched for the coming of her shadow along the wall the blessing of knowing that someone cared; a woman of great impersonal motherhood, a woman who could not be comforted because there was distress around her, and whose very presence brought peace, so the testimony goes, to men in pain from bullets and infections and the dreadful hopelessness of it all.

That in itself would be enough for books to have been written about Florence Nightingale; for it would remain one of the greatest legends of womanhood; something to put in our spiritual treasures behind the Gentle Mother Mary, and beside the Goddess of Mercy with her thousand hands.

But it is not all, and not nearly all. For it was only the emotional impulse of Florence Nightingale, and one aspect of her baffling personality. The other was the cold and efficient superintendent of nurses, who organised nursing in military hospitals, who put herself on paper with almost ferocious power, ordering Ministers of the Crown in England to do this and that, and giving them almost a scorpion's invective when they failed to be prompt and practical—a person to whom inexact thinking, and careless doing, was something to flail with her tongue and her pen, and who thought secretly that the government was a ludicrous succession of blunders that always ended in tragedy.

This book by Miss O'Malley is an important addition to the data of Miss Nightingale, and in the year's output of biography ranks very high. It is the first volume of a life which will, when it is finished, probably be the final authority upon her. It is built with admirable scholarship from the Nightingale papers, and throughout is thoroughly documented, so that the student of the history of nursing may have confidence in its adequacy.

It is also an interesting study in a woman's psychology, for the diary of Florence Nightingale is quoted, page upon page, and some of her early letters, and these show better than any secondary history could the development of her mind and her emotional nature. The inevitable conflict of the woman of mind with her inherited tastes and her normal instincts is confessed in her writing. We see her looking the men over, measuring, wanting to give herself, but holding back because there happened not to be one, certainly not one who was available, who could strike the fire in her which religion could strike, or the needs of the world. With the emotional capacity that was in Florence Nightingale a man would have had to be a religion to her, and she had too excellent a mind, and too well trained a mind, to have illusions like that about the men of her social world who were satisfied with life as it was. They say that afterwards Florence Nightingale met such a man in Sydney Herbert. Nobody knows. He was the husband of her dear friend, and whatever Miss Nightingale may have felt, and whatever Sydney Herbert himself felt, hardly matters. If it were so, it was tragedy which turned her the more inevitably to her destiny, and turned him, too, for without the help of Sydney Herbert in the Ministry the work of Florence Nightingale, either in the military hospitals of the Crimea, or afterwards

* Florence Nightingale, by I. B. O'Malley. Published by Thornton Butterworth, Ltd., 15 Bedford Street, Strand, London, W.C. 2, England. Price, 21s.

in the organisation of the training school for nurses, would never have been done. Whether he was a lover, or whether he was the selfless helper whom history always shows beside any person of a mission, cannot be known definitely, for lack of the exact record which history demands.

The book tells about the attraction of Miss Nightingale to the order of the Sisterhood, and her conviction as she grew older that Protestantism had erred in not providing an honourable vocation of service for such women as did not, for whatever reason they might have individually, care to marry. The great Catholic orders of teaching and of nursing were of incalculable inspiration to her. She is known to have spent time in retreat with the nuns of Italy and of England, though she was never received into the Church. It can be gathered clearly from her writings that she must have founded her school for nurses with the emotion of an Abbess founding an order for honourable professional outlet for such women who proffered to give themselves impersonally to the race in service rather than in the closely personal relation of the home, or who had to prefer it from lack of homes of their own. That, however, like the famous walk with the lamp, was only the emotional aspect of her purpose. Along with it went the knowledge that women when trained would make excellent nurses; that medical development needed them and would benefit by them. The Crimea proved to the Government that certainly the military hospitals needed trained women.

This first volume also covers the history of the Crimean experience,

and is based also upon letters and the records of eye-witnesses. The most interesting thing it discloses is the amount of intrigue with which Miss Nightingale had to deal. As we look back we accept the story of a strong woman with an indomitable conviction and a driving emotion sweeping everything before her for the betterment of conditions; but that is only the glamour of long distance. She fought her way painfully and uncertainly and with persistent enemies. The place was full of inefficient people whom nothing could make efficient; the Government was full of indifferent people, and its service was full of people who were only interested in making money for themselves. There were plenty of them to call her tyrannical, and a meddling old maid, and a hysterical fool who made babies out of the soldiers. War had been waged for centuries without women, and why try to save the remnant of armies anyway. There were a lot of handy arguments to cover up the commotion she created by her insistence upon sanitation and diet and clothing for the sick. But, however that was, there were always a few men who supported everything she said and did, and they were invariably men whose word counted. So the country of England accepted her, and gave her money in tribute for her services, and that money she turned to the establishment of the first training school for nurses.

Miss O'Malley's book will be interesting to those who are interested in the history of the nursing movement, or the academic feminist movement, and also to those who are curious about the inner workings of the minds of unusual women.

News Notes

BRITISH COLUMBIA

VICTORIA: At the December meeting of the Jubilee Hospital Alumnae Association a Court Whist Party was held in the Nurses Home. About forty members were present. Mrs. Bulloch Webster very kindly drew a ticket to decide the winner for the Hope Chest which was being raffled to raise money for the Bursary Fund, the winner being Mrs. A. Marling. The President presented the retiring treasurer, Miss J. Paterson, with a pair of silver candlesticks in appreciation of her services during her term in office and wished her good luck and best wishes for all future happiness.

MANITOBA

GENERAL HOSPITAL, WINNIPEG: Miss Ethel Johns, of New York, spent Christmas week in Winnipeg, during which there were many social gatherings arranged in her honour. On December 29th Miss K. W. Ellis, Superintendent of Nurses, held a largely-attended reception for Miss Johns. On December 1st Miss Johns joined the staff of the Committee on the Grading of Nursing Schools in United States.

GENERAL HOSPITAL, BRANDON: The regular meeting of the Graduate Nurses Association was held December 15th in the Nurses Home, Mental Hospital. After a short business meeting, Miss J. Anderson introduced the speaker of the evening, Dr. D. C. Cameron, who gave a very interesting talk on "The Cost of Mental Disorders and How It is Met". Mrs. M. Long, a recent bride, was presented with a silver carving set. Under the direction of the Doctors' Wives Group, the regular meeting of the Graduate Nurses Association was held Tuesday, January 5th, at the home of Dr. and Mrs. S. J. S. Peirce. Following a short business meeting, the members and their friends had the privilege of hearing the Rt. Rev. W. W. H. Thomas, Bishop of Brandon, in a graphic description of his memorable visit to Canterbury and London. Miss Blanche Brigham (Brandon General Hospital, 1928) is visiting her classmate, Miss Winifred Styne, who is seriously ill at Wadena Hospital, Sask.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in January, 1932, were 954, the same as in December, 1931.

APPOINTMENTS

Miss Josephine Follis, Hamilton General Hospital, 1929, has accepted a position with The T. Eaton Co., Hamilton.

DISTRICT 2

BRANTFORD: The annual meeting of the Ontario Red Cross Society, Brantford Branch, was held on Friday evening, December 11th,

at the Y.M.C.A. Dinner was served, followed by a short business session. The annual report of the Home Nursing Committee was presented by Miss E. M. McKee. The guest speaker of the evening was Captain Sidney Lambert, Padre of Christie Street Hospital, Toronto.

GENERAL HOSPITAL, BRANTFORD: Miss E. M. McKee, superintendent, entertained in honour of the student nurses at the annual Christmas dance on December 29th, in the Arcade. Following the dance, the nurses returned to the Residence for refreshments. Visitors in Brantford during the Christmas and New Year season were: Miss Florence Westbrook, (1921) of Ann Arbor, Michigan; Miss Aileen Mair (1926), of Brooklyn, N.Y.; Miss Helen Miller (1928), who is on the staff of the V.O.N. at Sudbury; Miss Helen L. Potts (1918), Superintendent, Woodstock General Hospital. Sympathy is extended to Miss Marguerite Zimmerman (1929) on the death of her father.

GUELPH: Miss Bliss and staff entertained the members of the Alumnae Association at a bridge tea New Year's afternoon in the Nurses Residence. Miss Watson and Miss Creighton are taking post-graduate work at the Hospital for Sick Children, Toronto. Miss Hall and Miss Lambert left January 4, 1932, to take a post-graduate course in Mental Hygiene at the Ontario Hospital, Whitby, Ont.

KITCHENER-WATERLOO: The Kitchener-Waterloo Graduate Nurses Association, held their annual social evening in the Nurses Residence on December 7, 1931. An interesting programme for the monthly meetings of the coming year was presented by the president, Miss K. W. Scott. During the evening presentations were made to the retiring president, Miss Winterholt, an attractive bridge set, and to the retiring secretary, Miss Elsie Master, a purse of money in recognition of her faithful services over a period of twenty-one years. Following a short business meeting, bridge was played and refreshments were served.

The Kitchener-Waterloo Alumnae Association held its annual Christmas meeting in the Nurses Residence on December 10th, 1931, and entertained the 1932 graduating class of the Kitchener-Waterloo Hospital. A short business meeting was held, in which the Executive of 1931 was returned to office for 1932. Gifts to the Community Relief Funds, the Kitchener-Waterloo Hospital, the Nurses Home, and the Nurses Library, were decided upon, and a pleasant social evening followed.

LONDON: The members of the Victoria Hospital Nurses Alumnae have pledged themselves to a donation of five thousand dollars to the Building Fund of the new hospital.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: The many friends of Miss E. Rayside, Superintendent of Nurses, will be greatly relieved to know that the critical operation under which she went at Peter Bent Brigham Hospital, Boston, in December, is reported as successful.

At the annual meeting of the Alumnae Association held on December 1st, officers were elected for the ensuing year. A hearty vote of thanks was tendered to the retiring president and her officers for their untiring efforts during the year. Following the business meeting, Dr. D. G. McIlwraith gave a very instructive and interesting address on "Maternal Welfare".

DISTRICT 5

TORONTO: A meeting of the Instructors' Section of the Centralized Lecture Course for Student Nurses was held on Friday, January 8th, at the Wellesley Hospital, twenty members being present.

The programme, arranged by Miss Palliser, proved most interesting—students of the preliminary class demonstrated eight procedures, ranging from the making of a linseed poultice to an intravenous infusion. The degree of dexterity which they displayed, with an entire lack of self-consciousness, was particularly commendable.

Following the educational part of the programme, Miss Ross, Superintendent, entertained the guests for a social hour.

WOMEN'S COLLEGE HOSPITAL, TORONTO: At a well-attended monthly meeting of the Women's College Hospital Alumnae Mrs. Isabel Ross, a representative from the National Council of Women spoke most interestingly and instructively along franchise lines, pointing out the necessity for the modern woman to study the laws governing votes at all elections, especially in this year of new problems. Although Mrs. Ross' address was by no means a canvass, those present were very much gratified to find her returned in Ward 9 on the Board of Education. Word has been received that Miss Jennings (1928) hopes to leave early in February for Central Brazil, South America. Miss Jennings is the second member of the Alumnae to do mission work in South America.

WESTERN HOSPITAL, TORONTO: The annual meeting of the Alumnae Association was held December 8th. Encouraging reports were submitted. Monies were granted to the Christmas Tree Fund for the Out-Patients' Department, and also for a course of educational lectures to be delivered weekly before the Association during the winter months. Election of officers for 1932 took place.

OSHAWA: Miss McWilliams, Superintendent of the Hospital, entertained the Alumnae in honour of Miss Marguerite Dickie (1925),

who is leaving for Vancouver to continue her studies before leaving for China as a medical missionary. Miss Dickie is the first member of the Alumnae to take up this important work. The best wishes of her sister nurses go with her in her new vocation. At the regular monthly meeting Dr. Archer Brown was the speaker of the evening. He gave a very interesting address on the subject, "What a Doctor Expects of a Nurse in a Home," which proved beneficial to all present.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The monthly meeting of the Alumnae Association was held on Monday evening, January 4th. The annual election of officers occupied most of the evening. The members of the Alumnae extend their deepest sympathy to Miss E. Hillyard in her recent bereavement.

WOMEN'S GENERAL HOSPITAL, WESTMOUNT: Miss Esther Thecter (1931), who received highest marks of any nurse writing the last examination for registration in the Province of Quebec, is now taking a course in science at McGill University. Miss Bulger (1931), owing to an accident, was unable to come to Montreal to write on the examination. Recent appointments to the hospital nursing staff are: Mrs. Drake (1930), Assistant Night Supervisor; Miss Morrow (1931), in charge of the Nursery; and Miss Moore and Miss Steeves (1930), floor duty. Miss Saunders (1931) is on the staff of the Laurentian Sanatorium, St. Agathe des Monts.

C.A.M.N.S.

VICTORIA: With sincere regret and sorrow the many friends of Miss Effie Alexander, R.R.C., learned of her death, which occurred on Sunday, November 15th, 1931, at the Jubilee Hospital, following an operation. Miss Alexander graduated from the Jubilee Hospital in 1908. After specialising in surgical nursing for several years she enlisted in August, 1915, with No. 5, Canadian Hospital Unit, and went overseas. She served in England, Salonika, Cairo, France, as well as seven months' transport duty, when she crossed the Atlantic twenty-four times.

On return to Canada Miss Alexander served with the S.C.R. at Resthaven, Esquimalt, Craigdarroch and Shaughnessy hospitals. In recent years she resumed private nursing. Gifted with extraordinary energy, kindness, a keen sense of humour and a deeply conscientious attitude toward her profession, Miss Alexander made innumerable friendships and was highly esteemed by patients, doctors and her fellow-nurses.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

- BROOKS**—On October 26, 1931, at Toronto, Ont., to Mr. and Mrs. Walter Brooks (Edith Gresham, Toronto Western Hospital, 1930), a daughter.
- BROWN**—On November 9, 1931, at Sydney, N.S., to Mr. and Mrs. Wm. E. Brown (Margaret Stiles, Wellesley Hospital, Toronto, 1923), a daughter.
- CLAZIE**—In November, 1931, at Ford, Ont., to Mr. and Mrs. John Clazie (Frances S-May, Toronto Western Hospital, 1923), a daughter.
- GIBSON**—On December 12, 1931, at Virden, Man., to Mr. and Mrs. Wallace R. Gibson (Mabel E. Box, General Hospital, Brandon, 1925), a daughter, Mary Ellen.
- GORDON**—On December 30, 1931, at Toronto, to Dr. and Mrs. M. K. Gordon (Blanche Hepburn, Toronto Western Hospital, 1928), a son.
- HALL**—On October 4, 1931, at Toronto, to Mr. and Mrs. T. J. Hall (Verna M. Reeb, Grace Hospital, Toronto, 1923), a daughter.
- HENDERSON**—In October, at Cumberland, B.C., to Mr. and Mrs. G. Henderson (Irma Knowlton, Royal Jubilee Hospital, Victoria, 1927), a daughter.
- KIRK**—On December 19, 1931, at Montreal, to Dr. and Mrs. C. M. Kirk (Edna Roderick, Children's Memorial Hospital, Montreal, 1930), a daughter.
- MARTIN**—To Mr. and Mrs. Chas. Martin (Alma Bryant, Victoria Hospital, London, 1923), a daughter.
- MacCALLUM**—Recently, at Toronto, to Rev. and Mrs. Clayton MacCallum (Jean Nicholson, St. John's Hospital, Toronto, 1926), of Mayo City, Yukon, a son.
- MILLER**—On November 19, 1931, at Port Carmen, Ont., to Mr. and Mrs. Miller (Agnes Crozier, Hamilton General Hospital, 1931), a son, Jack Sterling.
- ROBERTSON**—In October, at Powell River, B.C., to Mr. and Mrs. Robertson (Hilda Pelly, Royal Jubilee Hospital, Victoria), a son.
- SAVESAY**—In December, at Hamilton, Ont., to Mr. and Mrs. R. H. Savesay (Margaret Henderson, Royal Jubilee Hospital, Victoria, 1926), a son.
- SKIDMORE**—On December 25, 1931, to Mr. and Mrs. Reginald Skidmore (Hazel Shore, Victoria Hospital, London, 1927), a son, Lloyd Elgear.
- SMITH**—On January 9, 1932, at Toronto, to Mr. and Mrs. F. Smith (Flossie Goetz, St. Joseph's Hospital, Hamilton, 1927), a son.
- WYNNE-JONES**—On November 27, 1931, to Dr. and Mrs. Thos. Wynne-Jones (Kathleen J. Conway, Grace Hospital, Toronto, 1924), a son, John.

MARRIAGES

- BRADEN**—**NESBITT**—In September, 1931, at Lindsay, Ont., Jean Nesbitt (Wellesley Hospital, 1930) to Harry Braden, of Hamilton, Ont.
- CLARK**—**EMERSON**—Annie Emerson (Hamilton General Hospital, 1929) to F. Clark, of Caledonia, Ont.
- COLTMAN**—**EDMONDSON**—On December 9, 1931, at Echo Place, Ont., Ada Emelyn Edmondson (Toronto Western Hospital, 1928) to Ray Wilton Coltmán. At Home, 107 Fuller Ave., Toronto.
- DAVIS**—**GREY**—Recently, at Toronto, Audrey Grey (St. John's Hospital, Toronto, 1928), to Cyril Davis.
- FLEMING**—**CONSON**—On January 6, 1932, in Jarvis, Ont., Doris Conson (St. Joseph's Hospital, Hamilton, 1931) to Edwin Fleming, of Hamilton, Ont.
- GRAY**—**MACGREGOR**—On December 15, 1931, at Toronto, Ann Macgregor (Grace Hospital, Toronto, 1926) to Kenneth Curlette Gray, of Kirkland Lake, Ont.
- HAMILTON**—**BRUCE**—On November 28, 1931, in Hamilton, Ont., Margaret Bruce (St. Joseph's Hospital, Hamilton, 1931), to William Roberts, of Hamilton, Que.
- LEATHAM**—**SHAW**—On December 25, 1931, Ethel Shaw (Royal Jubilee Hospital, Victoria, 1929), to J. Leatham, of Duncan, B.C.
- LONG**—**CAMPBELL**—On December 1, 1931, at Brandon, Katherine Campbell (Brandon General Hospital, 1923) to Morris Long, of Brandon.
- McCLINTON**—**MOYER**—In November, 1931, at Preston, Ont., Helen Moyer (Wellesley Hospital, 1928) to Dr. Jas. McClinton, of Timmins, Ont.
- McFARLANE**—**ROSS**—On December 31, 1931, Evelyn Ross (Royal Jubilee Hospital, Victoria, 1928) to Roy A. McFarlane, of Seattle, Wash.
- McLEAN**—**BRYDGES**—On September 25, 1931, in Hamilton, Ont., Thelma Brydges (St. Joseph's Hospital, Hamilton, 1929), to Gordon McLean, of Montreal, Que.
- MEARS**—**BROWN**—Alice Brown (Hamilton General Hospital, 1925) to Robert Mears, of Palermo, Ont.
- NESBITT**—**WATSON**—Recently at Brooklyn, Ont., Stella Watson (Oshawa General Hospital, 1930) to Douglas Nesbitt.
- PIERMAN**—**PACKER**—On October 23, 1931, Mandie Packer (Royal Jubilee Hospital, Victoria, 1927), to Dan Pierman, of Victoria, B.C.
- RORKE**—**ATKINS**—Ada Atkins (Hamilton General Hospital, 1925) to Bert Rorke, of Winnipeg, Man.

SMELTZER—WILLIAMS—On January 2, 1932, at Lima, Peru, South America, Anna Gladys Williams (Toronto General Hospital, 1922) to Captain W. R. Smeltzer. At Home, Talara, Peru, South America.

STEVENS—CONNORS—On November 27, 1931, in Hamilton, Ont., Ella Connors (St. Joseph's Hospital, Hamilton, 1928), to Jack Stevens, of Hamilton, Ont.

TEMPLEMAN—STEWART—On October 17, 1931, at Hamilton, Ont., Isla Stewart (Niagara Falls General Hospital, 1929) to Herbert Templeman, of Little Falls, N.Y.

WILLIAMS—FRIZELLE—On January 12, 1932, at Montreal, Kathleen Lillian Frizelle (Ottawa Civic Hospital, 1929), to Robert H. Williams.

WILSON—TUCKER—Florence Tucker (Hamilton General Hospital, 1930) to David Wilson, of Galt, Ont.

WILSON—KITTINGINGHAM—On December 14, 1931, at Oliver, B.C., Gertrude Maria Kittingingham (Victorian Order Nurse and formerly with the C.A.M.C. N.S.) to Samuel E. Wilson, of Oliver, B.C.

DEATHS

ALEXANDER—On November 15, 1931, at Victoria, B.C., Effie Alexander, R.R.C. (Jubilee Hospital, Victoria, B.C., 1908, and formerly attached to No. 5, Canadian Hospital Unit, C.A.M.C.).

MISENER—On December 19, 1931, at the Stratford General Hospital, Mrs. W. Misener (Dorothy Muma, Brantford General Hospital, 1927).

MacMILLAN—After a short illness, pneumonia, in Lubbock, Texas, Minnie P. MacMillan, Superintendent of Nurses, Lubbock Sanitarium, and graduate of the Winnipeg General Hospital, 1904.

ONE-ACT PLAY COMPETITION

A prize of \$25 is offered for the best one-act play in a competition opened by the Canadian Conference on Social Work, which will meet in Winnipeg, June, 1932. The prize-winning play will be presented during this conference.

The rules governing the contest are:

1. The play shall be a one-act play, the presentation of which on the stage should occupy not less than twenty minutes and not more than forty minutes.

2. The play must depict some phase of social welfare work. It will be judged on its social value and on its dramatic and literary qualities.

3. The play shall neither have been published nor have been presented on the stage before being submitted in this competition, and it shall not be submitted elsewhere until the result of this competition is announced.

4. The prize-winning play shall be the property of the Canadian Conference on Social Work. For further publication and production permission shall be obtained from the executive of the said conference.

5. Three judges, whose decision shall be final, will be appointed by the Committee on Publicity of the Canadian Conference on Social Work. Award may be withheld, if in the opinion of the judges no suitable manuscripts are submitted.

6. All entries must be in by April 15, 1932. Result will be announced early in June.

7. Manuscripts shall be sent by registered post to the secretary, Mr. Percy Paget, 331 Legislative Buildings, Winnipeg. No manuscripts will be returned.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

A.A., WINNIPEG GENERAL HOSPITAL

Hon. President, Mrs. W. A. Moody, 97 Ash St.; President, Mrs. J. A. Davidson, 39 Westgate; First Vice-President, Mrs. S. Harry, Winnipeg General Hospital; Second Vice-President, Miss I. McDiarmid, 363 Langside St.; Third Vice-President, Miss E. Gordon, Research Lab., Medical College; Recording Secretary, Miss C. Briggs, 70 Kingsway; Corresponding Secretary, Miss M. Duncan, Winnipeg General Hospital; Treasurer, Mrs. H. I. Graham, 99 Euclid St.; Sick Visiting, Miss W. Stevenson, 535 Camden Place; Programme, Miss C. Lethbridge, 877 Grosvenor Ave., Membership, Miss A. Pearson, Winnipeg General Hospital.

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Chairman, Miss A. Boucher; First-Vice President, Mrs. F. Edwards; Second Vice-President, Miss V. Lovelace; Secretary-Treasurer, Miss M. Racey; Conveners of Committees: Nursing Education, Miss B. Bell; Public Health, Miss L. Young; Private Duty, Miss I. Sheehan; Publication, Miss M. Flannagan; Membership, Miss M. Siden, Miss D. Elliott; Social: Miss E. Hamilton, Miss Chiver-Wilson, Miss E. McTavish; Representatives to Board of Directors Meeting, R.N.A.O., Mrs. F. Edwards.

Meetings held first Thursday every month.

**GRADUATE NURSES ASSOCIATION,
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ONT.**

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A.A., BELLEVILLE GENERAL HOSPITAL

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charney; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

A.A., BROCKVILLE GENERAL HOSPITAL

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A.A., KINGSTON GENERAL HOSPITAL

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Regular Meeting—First Thursday of each month.

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A.A., GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO, ONT.

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A.A., RIVERDALE HOSPITAL, TORONTO

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A.A., ST. JOSEPH'S HOSPITAL, TORONTO, ONT.

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A.A., ST. MICHAEL'S HOSPITAL, TORONTO

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Mrs. H. M. Bowman; Hon. Vice-President, Miss Harriet Meiklejohn; President, Miss E. J. Henry; First Vice-President, Mrs. Scullion; Second Vice-President, Miss Eleanor Clark; Recording Secretary, Miss Jessie Wagner; Corresponding Secretary, Miss Grace Clarke, 46 Delaware Ave.; Assistant Secretary, Miss Margaret Free; Treasurer, Miss Bessie Fraser, 526 Dovercourt Rd.; Representatives to Central Registry, Misses A. Bankwitz, Lois Shaw; Representatives to District No. 5, R.N.A.O., Misses Isabelle Munns, Ella Flett; Representatives to Local Council, Misses D. Berry, T. Hawkes; Conveners of Committees, Sick, Miss May Roberts; Social, Miss Agnes McGregor; Councillors, Misses W. Worth, M. Chalk and V. Allen; Representative to "The Canadian Nurse," Miss E. E. K. Collier.

Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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A.A., HOTEL DIEU, WINDSOR, ONTARIO

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A.A., GENERAL HOSPITAL, WOODSTOCK

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

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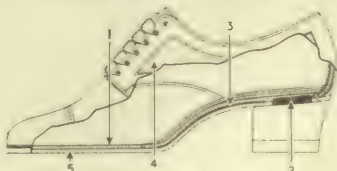
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Neuropsychiatric Nursing

By F. H. C. BAUGH, B.A., M.D., C.M., Homewood Sanitarium, Guelph, Ont.

Requests for information and advice regarding neuropsychiatric training for nurses have been so numerous that I am going to select a few of the most persistent questions and try to answer them. These requests come both from graduate nurses desiring to take post-graduate work in neuropsychiatric nursing and from young ladies contemplating a course in nursing.

I shall try to answer the following questions:

(1) Where can one take a post-graduate course in mental nursing? Can you tell me something about the course?

(2) If one is particularly interested in mental nursing, should one train in a mental hospital and then take some work in a general hospital, or should one train in a general hospital and then take a post-graduate course in mental nursing?

(3) What qualifications does mental nursing demand?

(4) What is the outlook for nurses with a special training in mental nursing?

It is regretted that up until very recently there has been no well organized post-graduate school for neuropsychiatric nursing operating in Canada. A few general hospital graduates get positions in our mental hospitals as instructors, etc., and in this way get some experience. I understand that a one-year post-graduate course in neuropsychiatric nursing will be offered at the Ontario Mental Hospital at Whitby, Ontario. The outline is attractive and follows fairly closely a course which is outlined in this paper. The medical men as-

sociated with it are enthusiastic and progressive. The institution is large and modern. The fact that it is in our own country and that nurses taking the course will most likely receive lodgings and pay should make it especially attractive. They will not be able to take a great many, but it is a start in the right direction. If the mental hospitals do put on such a course there should be a good deal of mutual benefit. The efficient graduate nurse, trained in a general hospital, would help to raise the standard of general nursing in the mental hospitals, and she in return would receive her special training.

If we had general hospital nursing courses reduced to two and a half years and then followed by a year's training in an active mental hospital there would, in all probability, not be the unemployment and hardship that so many nurses are enduring just now. Some of this may be due to the fact that in the not distant past a girl without much education could go into a mental hospital and train for three years and receive fairly good pay during her course. Then she would put in a few months in a general hospital, after which she could go out and compete with nurses who had put in three hard, unremunerative years in a good general hospital.

In the meantime there is a well-organised post-graduate school in neuropsychiatric nursing being conducted at the Veterans' Hospital, Bronx, New York. This has been established by the United States Veterans' Bureau to meet the increasing demand for nurses with psychiatric training. Lectures are given by the

doctors of the staff on the anatomy, physiology, and pathology of the nervous system. In the psychology course the correlation of structure and behaviour, emotions and instinct as driving forces in human behaviour, the rôle of intelligence, stream of consciousness, complex dissociation, rationalisation projection and mental conflict are subjects touched upon. Views of the leading psychologists on personality, psychoanalytic views, sex hygiene and the behaviour problems of children are presented. Lectures and demonstrations on clinical psychiatry, adequately covering all mental diseases, are given. Special lectures and demonstrations are given by the members of the hydrotherapy department. Of course, this includes instruction in the application of wet packs, continuous baths, and other forms of sedative treatment. There are lectures on occupational therapy, which include demonstrations in all the crafts, and illustrate the benefit of each on the different type of patients. The therapeutic value of occupation as it applies to all mentally sick people is emphasized.

They have the opportunity of studying the home conditions of the patients. The home is visited and prepared for the patient's return, and the patient goes home feeling that he has the support of the social service workers.

The nurses, along with the aides and social workers, attend the staff conferences. They hear the histories read and observe the method of examining the patient. In addition, the nurses visit the Psychiatric Institute and Hospital in the great medical centre, 168th Street and Broadway. This institution is planned, equipped and staffed to conduct special research, investigations into the cause, nature and treatment of all mental abnormalities and to aid all those who are caring for mental diseases to affect more efficient preventive and curative measures.

They also visit the Bloomingdale Hospital, where tremendous sums of

money have been spent in making the patients' surroundings beautiful as well as comfortable.

Had this question number two been put to me five years ago it would have been more easily answered. Conditions are changing somewhat. During the past year or so the Ontario mental hospitals have come under the Minister of Health—a medical man. It would appear that he is endeavouring to make them scientific, up-to-date hospitals. The old idea that any expense beyond custodial care is unjustified is, we hope, gone forever. Most of these institutions are well equipped and staffed to take care of all medical and surgical work that may arise among their patients. In many cases the general nursing instruction is given by competent general hospital graduates or by mental hospital graduates who have taken post-graduate work in general hospitals. Medical men are doing more research with the aim of finding both preventive and curative measures. Occupational therapy and social service work are being actively developed.

Some of the Ontario hospitals are so fortunate as to be situated close to medical schools. These have a decided advantage not only in regard to research work, but in the matter of good general clinical work in medicine, gynaecology and surgery. Such hospitals would seem to be excellent points at which to establish post-graduate schools in neuropsychiatric nursing. At any rate, the nurse who trains in one of the above hospitals and then takes a year of post-graduate course in a good general hospital should be able to meet all nursing requirements.

While the above advances are being made in the mental hospitals, the best general hospitals, realising that a knowledge of psychology and psychiatry helps nurses in their everyday work, are making an effort to give their classes lectures covering the above subjects. In some cases it is convenient to take these classes into mental hospitals to receive lectures and study cases. Some general hospi-

tals are developing a neuropsychiatric division, staffed and equipped to care for temporary, mild and early mental trouble. In this way nurses in training will get an opportunity to test their adaptability to neuropsychiatric nursing.

The recent development of travelling mental health clinics could be made to help general hospitals very much, both in teaching and in drawing clinical material, because naturally psychiatry cannot be taught apart from the mentally sick patient.

As regards qualifications, one must consider educational and personal qualifications. A young woman should have at least three years' high school training, or better still, be a graduate nurse. A good home training with an appreciation of good music, literature and art make an excellent background. She is armed with an ever-ready means of entertaining most patients and will be the more acceptable in cultured homes. No nurse can read and appreciate Dickens without being the better for it. Otherwise she is not likely to carry the course without difficulty and make a creditable showing in her R.N. examinations at its conclusion.

She should be sound in mind and body. Great size and strength, once considered so essential, are not stressed nowadays, since she who would use them to control a patient has no place in psychiatric nursing. The young woman with a pleasing personality, a good digestion, ability to sleep, and good recuperative powers after fatiguing duties is more in demand. No branch of nursing is more trying, nor does any branch demand such a thoroughly sympathetic understanding, so much self-confidence, self-reliance and control, resourcefulness, tact and diplomacy. She must be strictly truthful: most mentally sick people despise deceit and lying. She must always be the untiring patient's friend, protector and advisor. She must realise that mentally sick people are not account-

able for their behaviour and that they act as they do just because they are mentally ill. She should be quiet in speech and manner. The snappy, irritable type of young woman should never attempt a course in any kind of nursing. Most of the mentally sick people are hypersensitive—a sharp, grating voice, glaring lights, jangling keys, slamming doors, squeaky shoes often give unnecessary pain. Sometimes in spite of her best efforts she will get slapped, insulted, and perhaps have her hair pulled; and yet I have never heard a graduate in mental nursing say that she regretted having chosen the work.

The field for the nurse with a training in neuropsychiatric nursing is gradually broadening and will continue to do so. Along with a better understanding of mental illness by physicians, nurses and the public is the awareness that there is a mental aspect to almost every illness. Many medical and surgical patients are irritable, peevish, restless, impatient, or perhaps mentally depressed. The nurse who cannot appreciate the mental aspect of all this is likely to get into trouble and too often it is not altogether her fault. Physicians around a general hospital soon find out what nurses seem to get on well with difficult patients. The tragedy here is that so very few are born psychiatric nurses and the rest are out of luck for lack of training.

Each year sees an increased effort put forth by the Government to take care of sick people: mental health clinics provide openings, the National Committee of Mental Hygiene is gradually increasing its activities, and it is only a matter of time until school and industrial nurses will be required to have special training along this line.

It can be said, without any fear of contradiction, that the successful nurse of tomorrow must be an intelligent, sympathetic woman, equipped with a sound training in both general and neuropsychiatric nursing.

Editorials

PREPARATION FOR PSYCHIATRIC NURSING

In recent years there has been discernable, in discussions of nursing education, a trend toward including in the curriculum of schools of nursing, experience and instruction in psychiatric nursing. A recognised drawback to development of this type of nursing in Canada has been the lack of established and systematic organisation in mental hospitals, as is found in general hospitals, for the teaching of nursing. Quietly but effectively for a period of years medical men and nurses, active in the care of the psychiatric patient, have been inducing state health and welfare departments to allocate larger budgets to mental hospitals, until now in some provinces, if not in all, these institutions have progressed to the point where both undergraduate and graduate nurses can be assured the right type of training.

At the present time it is encouraging to learn that improved developments in our mental hospitals lead us to be assured that in future our nurses can obtain in Canada an adequate training in the care of the mentally ill. Those who have pioneered in this special field of nursing are to be commended for their perseverance. May they be rewarded in seeing from year to year an ever increasing number of graduate nurses with a knowledge of the theory and practice of the many aspects of mental hygiene nursing.

In Dr. Baugh's article on Neuro-psychiatric Nursing in this issue of the Journal he first asks several ques-

tions pertaining to this type of nursing, then he proceeds to answer those questions. In doing so, there is presented in concise language the educational and personal qualifications necessary for the young woman who contemplates becoming proficient in caring for the mentally sick patient and in promoting the spread of the principles of mental hygiene throughout the community. The article closes with what may be termed a word of warning when it states the belief that it is only a matter of time until school and industrial nurses will be required to have special training along this line, and that the successful nurse of tomorrow must be an intelligent, sympathetic woman, equipped with a sound training in both general and neuropsychiatric nursing.

HON. VINCENT MASSEY

THE Programme Committee are to be congratulated on arranging a very remarkable programme for the Saint John meeting. One needs only to mention the fact that the speaker of the first evening is the Hon. Vincent Massey. When Mr. Massey turns his mind to the problems of nursing, he will make a contribution that no nurse in Canada can afford to miss.

It may be that governments have "forgotten the nurse" in general schemes of state education, but when great public men such as Mr. Vincent Massey come to the assistance of the nursing profession, there is hope that the recommendations of the Survey Report may be put into effect in the not too far distant future.—J. E. B.

Taking the Profit Out of Nursing Education

By E. P. LYON, Ph.D., Dean, University of Minnesota Medical School, Minneapolis

[EDITOR'S NOTE: With the publication of the Weir Report of the Survey of Nursing in Canada, Dr. Lyon's article, reprinted from the November, 1931, issue of *The Modern Hospital*, is of peculiar significance.]

Since under the organisation of the University of Minnesota the nursing school is part of the medical school, the dean of the medical school ought to know something concerning nursing education. Through necessity, therefore, I have studied nursing education, read about it, talked about it with many people and latterly have sat at the knees of our Miss Densford, like a dutiful child, for many an hour.

I have found that nursing education is an elusive and complicated pattern. I confess that even now I do not know much about it, but I shall venture to express certain opinions.

One thing to which I have directed my mind is the organisation and control of nursing schools. I find that they are adjuncts of hospitals, that few of them have any relation to other types of organised education. Well, medical schools also are organised in relation to hospitals and depend on hospitals for indispensable facilities. But here I find a most significant, a most crucial difference. The doctors control the schools of medicine, the nurses do not control the schools of nursing.

The nursing schools are not in the hospitals because the hospitals have a high sense of educational responsibility, but because the hospitals have patients to be cared for and can secure this care cheaper by having training schools than they can without. A hospital recognises as its primary function the care of the sick. If, incidentally, the hospital can aid education it is willing to do so, provided it does not cost the hospital anything.

Ask any hospital superintendent, ask any hospital trustee whether he would continue to maintain a training

school if it cost the hospital more than the service of the pupils is worth. I venture to say that ninety-nine times out of a hundred the reply will be "No." Such a reply would be dictated not by lack of interest, but by lack of money. It is hard enough to keep the average hospital going. Few of them make money; most of them are money eaters, not able to live on what the patients pay. They run training schools to save money.

These two facts—that nurses do not control their educational institutions and that hospitals do control them and run them to save money—are at the basis of nearly all that is wrong with nursing and with nursing education.

Who Gets the Money that Is Saved?

The training schools save the hospitals money. That is what we say, and we condone the whole situation on that ground. When money is saved, however, someone saves it or, let us say, gets it. A bank does not save money for its customers. It is the depositors themselves who saved the money that is in the bank. If a corporation saves money, it goes eventually to the owners of the corporation. Now who gets the money that the hospitals save by having nurse training schools? This is a vital question.

No one, of course, takes cash out of the hospital till and transfers it to his own pocket, but this is the way that an equivalent transfer is accomplished. Suppose a private hospital doing a certain amount of charity service has to raise \$50,000 a year in donations from its wealthy clientele. If the nursing school saves this hospital \$10,000 a year the school is

really giving the hospital \$10,000 that otherwise it would have to solicit from its wealthy friends. The work of the nursing students leaves \$10,000 in the pockets of the rich patrons of the institution that they would have to give up if the institution were to continue on the same scale. The rich pay less for the privilege of being patrons of the hospital and for the wholesome feeling of being benevolent than they otherwise would.

Or let us suppose that an institution is living on its receipts from patients, neither losing nor making money. If the training school saves the hospital \$10,000 that it would otherwise have to take in and spend in order to break even, then the patients are profiting from the training school, because if it were not there the patients would have to pay a higher rate. The patients get the \$10,000.

Or look at a public hospital, a city hospital supported by taxes. The governing board or city council appropriates as little as will maintain the hospital on such a scale as the community approves. If the training school saves that hospital \$10,000, it is saving taxes. No wonder the city fathers approve of the city nursing school. All other city schools cost tax money, eat up a large proportion of tax money. Here is one type of education that not only costs nothing but saves taxes for other purposes. If I were a councilman I would say, "Let us by all means have more and larger nursing schools. If we only had enough such schools we could support the whole city government, including public schools, and abolish all taxes."

There is only one more possible case, the almost unknown one in which the hospital makes money. If the nursing school saves \$10,000, the owners get \$10,000 more in dividends than they otherwise would.

The Fundamental Defect

The training schools save the hospital money. The money that is saved goes in the long run to patients, to philanthropic donors, to taxpayers or

to owners or some combination of these, on the assumption, always, that the hospital is conducted on the same scale whether or not it has a training school. In any case the saving does not go to the nursing students or into their education. This is the fundamental defect of nursing education, the fundamental injustice that is being done to the nursing profession.

Nursing education will never be as efficient as it should be nor will it occupy the honourable status it should until the profit is taken out of its educational institutions. Profit is all right in business, at least so says our social philosophy, but in education it is wrong in principle and always has a bad effect on the quality of instruction supplied.

Nurses will never be able to control their educational institutions, they will never be able to regulate the number of such institutions, the character of the curriculum, the hours and type of practical experience, the kind and number of candidates admitted or graduated until the profit is taken out of nursing education.

The Grading Committee made a serious mistake when it stated in Part 3 of its report that there is no objection to hospitals making money on their training schools if the education provided is satisfactory. There is some saving grace in the proviso, for those really acquainted with education know that a fully satisfactory course cannot be supplied from the simultaneous earnings of students. Nevertheless, the statement is reactionary and will open the way for specious arguments for the continuation of the present system. The profit, all the profit, must come out of nursing education before the nurses can control and vivify their educational processes.

Too Many Schools!

A second result, as I have just implied, of the ownership and control of nursing schools by hospitals is that there are far too many schools. I was amazed recently to learn that they

number about 2,200. Over two thousand nursing schools in the United States and seventy-six medical schools! Twenty-two thousand nurses graduated in 1930 to join the ranks of the unemployed! The situation would be comical if it were not tragic.

When medical education was at its worst, about twenty-five years ago, there were 160 medical colleges, far too many and many far too poor. Even at the worst, however, these schools were controlled by medical men, amenable to medical opinion, influenced by medical tradition. When the profession as a whole, through the Council on Medical Education and Flexner Report, became aware of the conditions in medical education, self-respecting doctors could no longer run or remain connected with a profit-making college. An era of closing poor schools, of mergers and of transfers to universities ensued. In a few years the situation was changed completely. But in nursing, the building of new hospitals and the founding of new nursing schools goes merrily on. The more hospitals, the more pupil nurses, the more graduate nurses. But the more hospitals, the fewer sick persons outside of hospitals, the narrower the field for the graduate after she is out. Undoubtedly this is true in spite of the larger number of sick cared for by trained nurses now as compared with former times.

Suppose every business or industry needing ten or more stenographers should say: "We will have a stenographic school; we will have the president's secretary do the teaching (that will cost us nothing), the vice-president's and treasurer's secretaries will help (also without expense to us); we will keep our pupils three years and after the first six months expect them to do full work—including Sundays; we will give them board, lodging, laundry—and a swimming pool; at the end of three years we will have a little celebration, perhaps in a church, and give each one a cheap gold pin; we will then

take in a new group of girls to do our work; we will recommend our graduates to people who need stenographers; regretfully we may hire a few ourselves when we can't get student stenographers enough." Imagine the condition of affairs in the stenographic profession! And isn't this a fair if somewhat high-lighted picture of nursing education as it actually exists at the present time?

What Pupil Nurses Earn

How much do the pupil nurses earn—how much do they save for the patient, the philanthropic donor, the taxpayer, the owner? Few studies have been made, and most hospitals do not know. Phoebe Gordon, an instructor at the University of Minnesota School of Nursing, has studied this matter for the University Hospital and for the Miller and Northern Pacific Hospitals, St. Paul. Her figures, which no one has disputed, show that if the pupil nurses were allowed 35 cents an hour for their work after the preliminary period, each one would earn between \$100 and \$150 a year over and beyond all that is expended for her board, lodging, instruction and every expense connected with her education. Be sure to get this straight: if the hospitals paid these girls 35 cents an hour, which is less than one usually pays a maid, and then if each girl paid back to the hospital and to the university every cent that is spent on her for education, maintenance, uniforms and even her graduation pin, nevertheless the girl would take away with her at least three hundred dollars in cash when she graduated. What really happens is that she takes away a piece of paper called a diploma and leaves that \$300 behind in the pockets of the patients, the taxpayers, the philanthropists and the owners.

This \$300—if that be the right figure—that is earned by each student nurse during her course, if spent on her education, would entirely change the character of nursing education. Even then the student would be earn-

ing her entire education; it would cost the hospital nothing, the public nothing. Point to any other example like it if you can.

As a parallel case I studied the dental college at the University of Minnesota. Under supervision and instruction, the students do dental work for patients who come to the college. The university collects small fees for such a service. I find that the receipts for last year from this source were about \$50,000, while the material used amounted to about \$30,000. The difference, \$20,000, may be looked upon as the earnings of the students. What became of this money? It went to help support the dental college, that is, it went toward the education of the students who earned it, and with it went \$47,000 collected from the students for tuition and about \$63,000 of university funds. By university funds I mean tax money appropriated by the state legislature.

In the same year the pupil nurses at the University Hospital saved the hospital around \$20,000 above all expenses for maintenance and education, if their time is calculated at 35 cents an hour. Did this amount go into nursing education, as the dental students' earnings went into dental education? It did not. It saved the taxpayers of the state of Minnesota that much, or it saved the patients that much. Not a cent of it went into nursing education. Yet we speak of a "university" school of nursing!

I recognise the fact that our hospital could not have paid more for nursing education last year than it did—the appropriation for the hospital would not permit it—nor did we feel able to raise the fees of the poor people who came there. We are victims of the tradition, the stupid, selfish tradition, that provides that profit from nursing students must go to support our patients. This does not alter the fact nor modify the glaring contrast between the state's support of dental education on the one hand and the support of the state's hospi-

tal through nursing education on the other.

Some of my friends view the situation with equanimity. They say that others are exploited besides pupil nurses; that internes are exploited; that assistants and young instructors in the university are exploited. They talk of the valuable diplomas the nurses will get. They point to the advantages of training school life, speak of the protection afforded young girls during formative years, extol the habits inculcated, dilate upon the excellent (?) preparation for marriage, which will be the ultimate state of many of the nursing students. They talk a good deal like our pro-slavery ancestors, who were wont to condone slavery by speaking of the many masters who protected their slaves and treated them kindly.

Comparing Nursing with Other Education

I can't understand this point of view. The fact that in all other forms of education (at least for all students who are to engage in service as contrasted with business) more is spent than the student pays, while in nursing education the student earns more than she gets as education, revolts my feelings of justice and I want to do something about it. I ask myself, "Can anything be done?" I go over the cards the nurses hold with a view to seeing what their chances are of winning the game and securing what they earn and using this money for more adequate educational opportunities. The hand is not strong and there are few trumps.

The Ten Spot in the Nurses' Hand

First, there is the Grading Committee. I place the Grading Committee not higher than a ten spot at most in the hand the nurses have to play. The committee is too timid, too lady-like. Contrast its confetti pronouncements with the bombshells of the Flexner Report on medical schools. "Everything you tell us," says the Grading Committee, "will be regarded as confidential." Where-

as the Flexner Report fired broadsides in public print like this: "This school is one of the worst in the country"; or again, "At the date of visit, there was no outfit at all"; or again, "The clinical facilities are wholly inadequate"; or "This school is a wholly helpless affair." Your Grading Committee tells us what you already know about your own school and little about other schools.

Moreover, the Grading Committee has engaged itself with statistics and charts when what it needed was to hire a battery of artillery. The committee makes much of its fact finding and then naïvely acknowledges that the essential facts were already available, for example in the Rockefeller Report of 1923. Indeed, the facts are transparently visible to everyone who has eyes to see. Why collect statistics that there are too many nurses? When the average graduate has only five days' employment per month, as in Minneapolis, we do not need statistics, we need something done about it.

Among the forty or more recommendations of the Grading Committee there is no hint that the first necessity is to take the profit out of nursing education, no recognition that this is the vital point in the whole issue.

In spite of its enthusiasm and hard work, I don't think the Grading Committee will be highly effective, and when the hand is played out not even ten spot value is likely to be realised.

Then there is the card called propaganda, the creation or education of public opinion. Of course, the efforts of the Grading Committee are partly educational and are good as far as they go. I believe, indeed, that the general public is gradually getting a truer view of the situation in nursing. Some public interest has been shown, for example, in the paragraphs in *Time* for September 14, 1931. But the facts have been known to hospital superintendents, many of whom are nurses, for a long time. These superintendents are the real dictators of the schools, yet nothing

has been done. My guess is that nothing will be done until the situation is forced.

This condition had its parallel in medical education. From 1890 on medical educators and the Association of American Medical Colleges knew the weakness of medical education, and many individuals worked hard to improve conditions both in their own colleges and in the country at large, but the roots of a vicious system could only be blasted out when the organised medical profession and the Carnegie Foundation exploded the dynamite of the Flexner Report.

The organised medical profession could explode and did explode that dynamite. Can the nurses do the same thing? I am afraid not. Their lady fingers are not accustomed to handling explosives. Furthermore, I am afraid that some doctors, not understanding the situation, may keep the nurses' hands tied. I give educational efforts about a six spot value.

But the nurses do control the teaching in the sense that they are the only teachers available. If they were able to present a united front, if they could bring themselves to declare a moratorium in nursing education, if they would say "no more apprentices for so many years," as the carpenters or bricklayers or locomotive engineers would say in similar circumstances, and if they would hold to such decisions—no scabs in their group—then something would happen and it would happen quickly.

But you say, "Oh! we couldn't do that! There are the patients to be cared for. That is our glorious tradition. That is our first duty."

Dear misguided ladies! Do you not know that if you issued an ultimatum that after January 1 there should be no pupil nurses in any hospital anywhere, the patients in those hospitals would be just as well cared for as they are now? Do you not know that the philanthropist, the patient, the taxpayer and the owner would find the money you have been saving

for them? Do you not know that the nurse students would be promptly replaced by graduates who are idle at the present time? If you do not know these things then you do not know the tremendous strength that is yours if you saw fit to use it and could act solidly and as a unit in fighting this battle.

Will Nurses Heed This Plea?

Can you not feel the terrific public appeal of such a slogan as "No more nursing students until the profit is taken out of nursing education?" And the interesting fact is that not one of you would go to jail. Not one superintendent of nurses, not one supervisor would lose her job. The hospitals would have to keep you, for your primary work is caring for the sick and not teaching. All that this programme needs is courage.

There is talk of cutting down the production of cotton, of wheat, of various crops of which there is an unmanageable surplus. Why not cut down the crop of nurses? I'll tell you why. Because the profit in nurse farming is not in selling the crop, but in growing the crop. We leave the crop to sell itself, if it can. Why not have more consideration for the crop? Why not plow in nine rows out of ten, or stop production altogether for a while?

Trade Union Methods Suggested

If hospital superintendents had to sell their nurse graduates to get their profit—that is, find each one a job—these superintendents would have run to the Farm Board long before this. They would want the Government to take the whole crop off their hands. As it is, the nurse teachers are the only ones who have power to limit nurse production, and the nursing profession, not the hospital superintendents, has an interest in so doing.

But you are timid, you are not solidly organised, you are poor. You say you cannot use trade union methods, forgetting that the doctors, the lawyers, even the college profes-

sors, have union though called by other names. On your power to control production through withholding nurse teaching I give you about a five spot rating compared with the ace that the American Medical Association played when it declared itself in favour of two years' pre-medical college work and formulated the minimum standards for an accepted medical school. The ace took the trick, forced the game. The five spot—well, it could grow to be an ace if you so willed. If you so willed!

The nurses control, I assume, the standards of admission to their own societies. I assume that these bodies could decree that after a certain date no one could secure membership who had been trained in a hospital that made money on its nurse students. I assume that they could declare that no one might retain membership who accepted employment in such a hospital. But I know they won't do any of these things, and I give a four spot value to all that organised nursing will do in a positive way to improve present conditions.

The nurses control or seem to control the boards of nursing examiners whose fiat turns the graduate nurse into a registered nurse. These boards could enforce, or it seems as if they could enforce, rules regarding recognition of acceptable schools. They could refuse to recognise graduates of schools that make money on nursing education, schools that exploit their pupil nurses. The boards of medical examiners define acceptable medical schools and refuse to examine graduates of non-acceptable schools. Could the boards of nursing examiners do the same? Possibly, but my guess is that they could not present a united front for such an end and that, if they did, they would meet opposition from certain medical men, honestly doubtful, most of them, as to the value of nursing education. However, this card has possibilities and I value state board influences as a nine spot, at most, in the hand the nurses have to play.

These are your cards. What can you expect in your partner's hand? The interesting thing is that you don't know just now what partners you may have, but there are intriguing possibilities.

There is the American Medical Association. I understand that the American Medical Association is not participating in the Grading Committee's work. Still, I cannot believe that the association will keep completely out of a game in which so much is at stake for its age-long ally, organised nursing. If I were you I would put on my prettiest smile and try to vamp the American Medical Association on the crucial point of squeezing the profit out of nursing education. The doctors are honourable and intelligent. They have only to recall the days of profitmaking medical colleges and the educational havoc that resulted. They are eminently just when they understand a situation. Just now they are inclined to condone the present system because it has existed so long. Who knows, if they get a true view of the conditions but they may be brought into the game with all their strong cards, such as approval of hospitals for internships? Think of the rattling of dry bones that would be heard if the Council on Medical Education and Hospitals would announce that after 1935 there would be no approval for internship in a hospital that make a profit on its student nurses!

The A.H.A. as a Partner

There is the American Hospital Association, composed largely of those terrifying dictators of nursing education, the hospital superintendents. But of course they are not really terrifying. Rather they are your friends. They, like the rest—doctors, nurses, the public—have been victims of tradition. The superintendents are not entirely free any more than you are entirely free. They are responsible to trustees and political influences. They may not relish the prospect of having to raise from none too prolific

sources the money needed as a substitute for what the pupil nurses earn. But if they had to raise it they could and would do so. Perhaps the American Hospital Association might be induced to pay such a tremendously potent card as : "No membership for hospitals that make a profit on nursing education."

The American College of Surgeons possesses enormous power. Can the college be induced to pronounce the vital principle, "No profit in nursing education," as one of its criteria for approval of hospitals? What a card if they will only play it! Even the bluff of playing it would win the game.

These, as I see it, are the cards you hold and the cards your partner may hold. Now what cards have your opponents? Yes, they have a strong hand.

First, there is tradition. Nursing education began as an adjunct, an ancillary function of the hospital. (I looked up that handsome word ancillary and found that it is derived from the Latin word for female slave.) The nurse students have always served the hospitals free. The tradition of free service will be a hard one to break.

Can Nurses Stop Giving Free Service?

I should like to live a hundred years more for just two reasons: first, to see whether the nurses can break the tradition of free service—in other words, whether they can collect from the philanthropist, the taxpayer, the owner, and the patient the money that rightly belongs to them for their education. Second, I should like to live long enough to see whether the doctors can break the equally vicious tradition that they must take care of the poor for nothing. The public, the taxpayers, should be responsible for the sick poor and should pay the doctor, and the nurse also, for services to the poor, just as they pay for their beds, food, fuel and shelter.

A second card your opponents hold is vested interest. They have lived on it for many years. It will be hard for them to give it up. They will have to raise in some other way the money they have "saved" on their training schools. The philanthropist, the owner, the taxpayer, and the patient will not voluntarily regurgitate. Will you use an emetic strong enough? I have shown you one, but I doubt whether you will administer it. You will wait, I presume, for a doctor's prescription. If so, you will wait.

A third card in your opponents' hand is the psychology of the position you occupy in the hierarchy of healing. Your position is exactly described by the word ancillary. Individually you are accustomed to take orders. Your initiative is limited. Your rank and file look to the medical profession rather than to organised nursing for canons of action. I am afraid that this card will cancel the value of all the trumps you hold.

However, the game is on, put on a poker face and play your best, and I for one shall watch with much interest the fall of the cards. You deserve to win, and I hope you do win.

This address is intentionally dogmatic and provocative. I am aware that things I have said are not true in particular instances and situations, but I have purposely avoided the particular and the exception. On the other hand, as you all see, there is nothing new in this address—no new facts, no new thought unless it be the analysis of who actually profits by the earnings of the nursing students. The newness, if any, is in emphasis. Of all the difficulties and shortcomings of nursing education I claim that the basic casual factor is the profit in it. I claim also that practically all criticisms of nursing have the same cause. I presume to make a diagnosis. The nurses as expert therapists should take upon themselves the responsibility for treatment. Others may assist but, as I see it, the nurses must be responsible for it, must do most of the work.

I have put forward as a leading thesis the claim that the trouble with nursing education is the profit hospitals make out of it. As I see it this is responsible for the number of schools, far in excess of the need; for the over-production of nurses; for the poor quality of many students of nursing and for the many incompetent graduates; for the unsatisfactory curriculum adjusted to hospital needs and low grade students and not to the educational requirements of superior women; for long and health-destroying hours of duty; for a condition of affairs in which, in many instances, one cannot distinguish between the R.N. and the practical, because one is as good or as bad as the other.

Let Nurses Control Their Schools

Take the profit out of nursing education. Give the nurses control of their own education. Under such circumstances they could determine how many schools they need and make their contracts with suitable hospitals willing to co-operate in nursing education. If a hospital will pay its co-operating school all that the students earn in service, that hospital will be no worse off and of course no better off than its neighbour hospital that has no school and hires graduate nurses. The incentive for multiplying schools will be gone. The proper number and quality of nurses will be trained and these, when graduate, will find employment. The whole situation will become sane and dignified. With sanity and dignity will come in time, I sincerely believe, as they did to medical education, the endowment and public support needed to raise nursing education to the level of the other professions as far as culture, scientific background and intellectual average are concerned. Take the profit out of nursing education and all else to be desired will come into it. This is my thesis, my diagnosis.®

(®Read at the meeting of the Minnesota State Registered Nurses Association, September 24, 1931, and the Illinois State Nurses Association, Chicago, October 15, 1931.)

Some Features of the Report of the Survey of Nursing Education in Canada

(As released to The Canadian Press, February 12th, 1932)

The Survey of Nursing Education in Canada was initiated and, for the greater part, financed by the Canadian Nurses Association in co-operation with the Canadian Medical Association. This action was taken in order to get at the facts of the nursing situation in Canada.

In 1927, the Canadian Nurses Association and the Canadian Medical Association appointed three representatives each to form a National Joint Study Committee. This committee was entrusted with the responsibility of devising ways and means for undertaking the Survey. The committee decided that the Survey must follow scientific methods and that it should be made by a specialist in education. Professor G. M. Weir, Professor of Education in the University of British Columbia, who, some years ago, conducted a Survey of Education for the Government of British Columbia, was asked to make the Survey of Nursing Education. Fortunately, the Board of Governors of the University of British Columbia, realising the necessity and importance of this work, were good enough to give Professor Weir leave of absence for almost two years in order to undertake it.

The completed report deals with many angles of nursing education and nursing practice. The committee now submits the whole report to the careful study of the nursing and medical professions and to the general public, trusting that it may form the basis upon which will be built a constructive plan for the improvement of the nursing service in Canada.

The following headings will give an idea of some of the most important aspects. The recommendations are

Dr. Weir's and are printed as a basis for discussion:

I. Economic.

The whole question of nursing education is bound up with the finances of the hospital. The opinion commonly prevails that the training school for nurses provides cheap nursing for the hospital; hence the protests of small, inadequately equipped training schools against closing their schools and staffing their wards with graduate nurses. The Survey has some interesting facts to present on this problem, based on a study of costs in 33 representative training schools—9 small, 15 medium size, 9 large—well distributed throughout Canada. The fact is that under present conditions there is an annual loss to the average hospital in Canada for each student that is receiving a satisfactory training in nursing. But in a number of the cases of small schools brought to the attention of the Survey, their pretence at offering an educational course of training should be considered little more than mere sham.

The necessity emphasized throughout the report is that training schools for nurses should no longer be left to the haphazard methods of individual hospitals, but should be subsidized, controlled and supervised by the Government in the same way as normal schools are. An approved training school should be defined by law, and hospitals, otherwise qualified, should not be legally authorised to establish training schools unless on the explicit written statement of the Provincial Board of Control.

To quote from the Report in regard to the necessity of subsidizing training schools for nurses:

"Surely the state is no longer justified, in the face of unimprovable

facts, in complacently standing by and ignoring its duty to contribute to a great national enterprise—namely, the education of the student nurse. . . . There is no more valid reason, when all the facts of the situation are impartially weighed, why, for instance, the state should pay the costs of normal school education than that it should pay the cost of educating student nurses. It is admitted that the state is justified in insisting upon adequate standards of nursing education, involving efficient inspection and supervision of the nurse in training and in service, as a condition precedent to the granting of financial assistance. And such competent supervision, kept clear of all partisan influence, would be welcomed by the true friends of nursing education. . . . From a financial viewpoint, nursing education should be made an integral part of the provincial educational system as is the education, for instance, of the teacher. . . . Furthermore, it is scarcely subject to serious doubt that the adequate training of the nurse is at least as complex as that of the teacher. Fully as much laboratory equipment and library facilities, for instance, should be available for the professional education of the former as for that of the latter. The quality of the instruction in each case should be reasonably equivalent. That this relative equality, by no means exists—with the exception of certain nursing schools in medical centres or university courses for public health nurses—will be manifest to anyone who impartially studies the situation. From the viewpoint of teaching facilities and equipment as well as quality of instruction, the standards obtaining in the average training school for nurses in Canada are distinctly inferior to those found in the average high school or collegiate institute, not to mention the average normal school. As a matter of fact, the full-time instructor, even in the best type of training school for nurses, is a comparatively recent innovation. . . . Poorly equipped schools

for the training of doctors, lawyers, or teachers are no longer tolerated. And there is no valid reason for the training of nurses being placed in a different category. . . . To use Lord Durham's classic stricture in a new setting, the nursing profession cannot 'remain an old and stationary society in a new and progressive world.' "

II. *Educational Standards.*

The Report points out the glaring disparity between the best and weakest schools in regard to

1. *Preliminary Education.*

In some of the small schools, students with only grade VI. standing (elementary schools) are found. In the large schools some university graduates are enrolled—yet all are preparing for the same R.N. examinations.

The requirement of two years of high school, specified by most Registration Acts in Canada, is frequently flouted or ignored.

2. *The Content of the Curriculum* as between the poorest and best training schools shows great variation, such as would never be tolerated in high schools or normal schools.

3. *The R.N. Examinations* are, on the average, a sieve with wide meshes.

The failures on the departmental examinations (conducted by the various provincial departments of education) are, in percentages, about four times the failures on the R.N. examinations, yet the former are educationally very reasonable.

The methods of marking the R.N. examination papers show wide variabilities as shown in the Report. For instance, in an experiment conducted by the Survey fifteen experienced examiners (who teach in training schools) awarded percentages ranging from 11 to 58 for the same examination paper.

4. *Lecture Method in the Classroom.* In the average training school, this method usurps about 75 per cent. of the time given to instruction. Students are "lectured at" more than they are taught.

5. *Housemaid's Work*, which after the first six months or so has lost its educative value in the actual nursing training, accounts for nearly 37 per cent. of the student's time in the average training school. This means work that a housemaid could be reasonably trained to do.

6. *Size of Hospital Conducting a Training School*. The minimum size, according to medical and nursing evidence, should be 75 beds with a daily average of 50 patients. Closure of schools under the above size would reduce the number of student nurses by 13 per cent.

7. *Theory and Practice*. Medical and nursing evidence shows that too much time, in an absolute sense, is not given to theory in the training school, but that much of the curriculum in general should be subject to revision. Practice should not be increased at the expense of properly selected theory.

III. *Over Supply of Nurses.*

At present there is no correlation between the needs of nursing services and the supply of nurses being turned out. The hospital hands each of the members of the graduating class a diploma, wishes her God-speed, and feels no further responsibility. It doesn't matter how serious the unemployment problem may be: the hospital takes in its same quota of student nurses each year.

At the time the field-work of the Survey was completed (autumn of 1930) it was estimated that there was a surplus of graduate nurses in Canada—with the exception of public health nurses and full-time instructors, of whom there is a shortage—of about 40 per cent. It is a serious and critical situation that about 40 per cent. of the private duty nurses in Canada as a whole are almost continuously unemployed; about another 20 per cent. are only intermittently employed.

IV. *Distribution of Nursing Services.*

Although 40 per cent. of private duty nurses are constantly unemploy-

ed, the amazing fact is disclosed by the Survey that 60 per cent. of the cases of average acuteness (not colds or minor illness) in Canada are reported to be cared for by non-trained attendants. A density and distribution map shows in graphic form that 25 cities, which account for one-third the population of Canada, have the services of about two-thirds of all active registered nurses.

There is also evidence that only three out of eight patients of moderate means who need the graduate nurse are able to engage her. Hence the need for a socialisation of nursing service.

V. *Socialised Nursing Service.*

There is a growing dissatisfaction throughout Canada with the high cost of health services. Unthinking people have blamed this on the nurse, but now an informed public sentiment is looking towards some form or method of socialising health services. Socialisation would largely bridge the gap between the needy patient, unable to pay graduate nursing fees, and the unemployed graduate nurse, unable to market her services in over 60 per cent. of the cases of illness.

In its analysis and advocacy of the principle of socialisation of nursing services, the Survey emphasizes the following points:

1. *The principle of ability to pay*. There should be no pauperising; at the same time an effective socialisation of health services should supply these services to the average patient at less cost than at present and in more abundant measure.

According to unverified evidence reported to the Survey by social workers, about 50 per cent. of the families in Canada live on an annual income of approximately \$2,000 or less. After meeting the costs of living, it is obvious that, on the above basis, over 50 per cent. of Canadian families have practically nothing left for hospital, doctors', nurses' or dental charges.

2. *Compulsory state health insurance under defined income limits for three classes:*

- (a) Wage-earners.
- (b) Salaried people.
- (c) A class enjoying certain financial independence in the sense that they belong to neither of the above classes, such as small merchants, retailers, druggists, butchers, bakers, farmers, etc.

It might be financed by contributions from the following sources:

- (a) The insured.
- (b) The employer (in the case of salaried people and wage-earners).
- (c) The Provincial Government.
- (d) The Federal Government (if possible).

3. *Re-organisation and Control of Nursing Services:*

- (a) Registration of nurses and assignment of their duties under conditions that take account of personality and adaptability factors as well as of academic and professional qualifications might be made effective.
- (b) In addition to a more scientific inspection of training schools, provision might be made for the supervision of the nurse in services with the object of promoting her professional growth.
- (c) A system of superannuation for nurses, similar to that now enjoyed by teachers, might be arranged.
- (d) Continuous employment for nurses should become feasible in the light of two conditions, viz.: the removal of the economic barrier between the patient and the nurse and dealing with the fact that only about 40 per cent. of the people sufficiently ill to profit from the services of the graduate nurses now engage them.

- (e) Control of nursing services might be in the hands of Provincial Councils of Nurses working in co-operation with a Federal Council.

4. *Federal Council of Nursing.*

This might be a creation of the Federal Parliament, if possible, and subject to a Dominion Board of Control on which the Canadian Nurses Association should hold the majority representation. Representatives of the Canadian Medical Association and of leading lay organisations should also be appointed on this board.

It might exercise functions of an advisory, directive, educational, research and integrating nature. Under section 93 of the B.N.A. Act this council, being federal, could scarcely be clothed with powers of a legislative nature; but it would probably serve as the brain, in an advisory sense, of the various provincial councils discussed below. Its headquarters, both from the viewpoint of population and geography, should be as centrally situated as possible. Its activities would be of a much more scientific nature than serving merely as a clearing house for ideas on nursing conditions.

5. *Provincial Councils of Nursing.*

These councils would be created by provincial enactments and would exercise functions, with the advice of the federal council discussed above, chiefly of an executive and administrative as well as educational nature.

Compulsory registration with these councils of all who care for the sick for hire—including attendants, visiting home helpers, practical women, as well as trained nurses—should be adopted.

The prime function of provincial councils would be to organise and supervise the work of private duty nurses and various types of attendants who care for the sick for hire. Private duty nurses, working directly through local or district registries as part of the provincial organisation, could be given continuous employ-

ment on a regular salary basis. These district registries would serve as branches of the provincial council, working under the direction and supervision of the latter, and bringing the types of nursing services required to the home of patients. The adequate placement of these services would be largely conditioned by the studies of local nursing needs made by provincial councils and by the establishment of effective contacts with the medical profession, training schools, hospitals, departments of health, and with other agencies concerned with the care of the sick.

The question arises as to whether all private duty nurses should be obliged to work under the direction of the Provincial Council of Nurses, and, if so, would there be sufficient employment to keep all those nurses continuously engaged. The following aspects should be emphasized:

- (a) Nurses who prefer to remain "free-lancers" would be permitted to do so, but patients of the insured class obviously would not engage free-lance nurses.
- (b) Medical evidence, confirmed by the laity, shows that the majority of patients in Canada generally, who need the services of the trained nurse, are now unable to engage these services. It is probable that under a plan of social health insurance all the trained private duty nurses now available could, under an adequately organised and controlled system, be given employment of a reasonably continuous nature.
- (c) The Provincial Council and nursing registries should supply a scientific nursing supervision as a reasonable assurance of efficient nursing services.
- (d) A Provincial Board of Nursing Control, the creation of the Provincial Legislature, should be established to advise and control the Provincial Nursing

Council. This board should be free from political intervention and should be as autonomous as a University Board of Governors. As the problems to be dealt with are primarily those of the nurse, her profession should hold the majority representation on this board. The nurse members might be appointed for a term of years by the Provincial Nurses Association. The Provincial Government, the Provincial Medical Association, and the laity should also be represented on this board.

- (e) The chief duties of the board would be administrative, including the appointment of the Provincial Director and other necessary officials, such as the inspector of training schools, supervisors and district registrars.

6. *District Registries.*

These registries would be under the supervision of the Provincial Council of Nursing and would supply the nursing contacts with various classes of the community. Various types of nursing services should be made available, such as: visiting nursing, hourly nursing, daily nursing, special services such as surgical, maternity, paediatric, and so forth.

Registries should be established in the less populous areas—especially those outside of, as well as within, rural municipalities—and the services of nurses made available under controlled and supervised conditions, to the rural population.

7. *Finance.*

The chief sources of revenue of financing a socialised nursing service may be found in the following:

- (a) State health insurance.
- (b) Federal assistance.
- (c) Fees (nominal fees to insured patients).
- (d) Hospital tax on meals costing \$1.00 and more.
- (e) Tax on luxuries, especially on liquor.

Hard Times

Everyone knows that for two years we have been having "hard times," not only in Canada but all over the world. Our readers have no doubt heard many explanations of why this is so. Mr. Richard Whitney, President of the New York Stock Exchange, in an address to the Merchants' Association in September last, said that in order to reach an understanding of the present depression it is necessary to go back to a well-known law of economics—the law of supply and demand.

According to the law of supply and demand, prices represent the relationship between the available supply of any commodity and the demand for it. When the supply is greater than the demand, prices fall. On the other hand, when demand is greater than supply, prices rise. Since both supply and demand frequently change, the relationship between them is bound to change, too, and for this reason prices go up and down.

Prices, therefore, have a corrective influence in business. When prices rise, producers are naturally stimulated to increase the supply, but meanwhile demand is curtailed because the consumer's money will purchase less. On the other hand, when prices fall, the producer's profits dwindle and cause him to lessen his production, but at the same time the purchaser's dollar will buy more, and thereby, sooner or later, demand is increased. In the long run it is price which tells the producer how much to produce, and the consumer how much he can buy. In this way, prices regulate business.

During the war, the normal law of supply and demand was replaced by abnormal conditions. The countries engaged in the war had to take speedy measures to equip and maintain their armed forces. The demand for some kinds of goods was greatly increased, for other kinds greatly decreased. Prices for certain products were con-

trolled by governments. After the war, the governmental controls in business were removed, and the pent-up forces of supply and demand again exerted themselves, first in a brief boom, and in 1921 in a sharp, world-wide depression.

When prosperity came again after 1921, attempts were made in several countries to prevent future depressions. It was thought that there might be a way of dodging the consequences of this law of supply and demand. In Canada, wheat pools were established to steady the prices of wheat, and experiments in cotton, copper, coffee and rubber were tried in other countries.

The effect of these experiments was to increase the price of the commodity, and this in turn led to increased production. This was very pleasant and agreeable, and for a few years it looked as if this state of affairs would go on indefinitely. But very largely increased production was bound in the end to overbalance the demand, and thus lead to lower prices. The fact that this adjustment was delayed in the prosperous years following 1921, only made the collapse in prices all the greater when it did come.

During the same period, there was another kind of interference with the law of supply and demand. This was through rising tariffs and even embargoes. Whether through fear of future wars or through new ideas of national prosperity, nations began to direct their efforts towards producing all or nearly all the things they needed, so as not to have to import commodities from other countries. The effect of this was again to increase and maintain high prices, and so production soared far beyond the demand. It is therefore not astonishing that in the long run a point was finally reached when the volume of production could not find sufficient buyers and in the end prices fell with a crash. Once again, the law of supply and demand took its revenge.

It is misleading to regard the present depression as a disease. It is much nearer the truth to think of it as an ebbing tide. For hours the waters recede, and then when they have reached the farthest point, the ebb tide ceases, equilibrium is re-established and gradually the waters return to the shore.

So, too, it is in business. Before the flood-tide of prosperity can return, invisible under-currents must exhaust

themselves. Like the tides, these forces are little subject to human control.

Meanwhile, we may rest assured that the law of supply and demand was not suddenly abolished a few months ago. It is still working vigorously. It has caused a drop in prices and thus hard times, but the same economic forces will bring in more favourable conditions. In fact, it begins to look as if this reaction is already setting in.—J. E. B.



Beach at
Point du Chene,
New Brunswick



Along the
St. John River
at Meductic

*The Sequelae of Diphtheria**

By H. B. CUSHING, M.D., Montreal

Of all the acute infectious diseases of childhood, diphtheria is the one concerning which we have the most accurate knowledge. Not only are we thoroughly familiar with the cause, symptoms and course of the disease, but we have at our command efficient methods for diagnosing the disease, curing it, preventing it, and, in short, for absolutely eradicating it in any civilised country. In other words, diphtheria has no license for existing or for having a death rate. In spite of all this, diphtheria is still one of the chief causes of death among young children and is the third most important cause of death in children under five years of age in this country: only diarrhoea and pneumonia are more common. This being so, one may be excused for spending a little time inquiring into the cause of these deaths and be sure of discussing a subject of importance to everyone.

Children with diphtheria die from two causes, broadly speaking. They either suffocate from membrane in the larynx or lungs, or they die from the effects caused by diphtheria toxin on the organs of the body. I wish to speak only of the effects caused by diphtheria toxin. Diphtheria is a local disease: toxin is produced at the site of the lesion, usually in the throat, absorbed, and acts on the various organs. It is a slow poison, taking some weeks to produce all its effects. The dose of the poison any given case has received when it first comes under observation can be approximately estimated by the extent of the local lesion and its duration before the antitoxin is administered. An adequate dose of antitoxin prevents any further damage, neutralises any toxin in circulation, or which may be produced later, but is of no avail in counteracting the toxin al-

ready absorbed and fixed in the tissues.

There is a prevalent impression that the action of the toxin is most uncertain, causing heart failure in one patient, nephritis in a second, bizarre forms of paralysis in a third, and so on without any definite rule or reason. This is not so: if one observes carefully a large series of cases one finds it possible to estimate, as I have indicated, the approximate dose of toxin received and to prophesy more accurately than in most diseases the subsequent course of events. The action of the toxin is surprisingly uniform, and although naturally one individual differs from another in his resistance and reaction, still the after-effects of a severe attack of diphtheria are remarkably similar in all cases.

Let us consider these effects more in detail. For clinical purposes, diphtheria affects three organs only, the kidneys, the heart and the nervous system. It may affect others, presumably does so. In fact, from autopsy findings and animal experiments, it probably affects the thyroid, liver, pancreas, and especially the suprarenals. But so far as our present means of observation go, we have no facilities for accurately estimating the damage to these organs, and the effects on them apparently do not influence the clinical picture. Let us confine ourselves then to the three organs which give obvious clinical signs or symptoms.

The first evidence of the effect of the diphtheria toxin is from the kidneys in the form of nephritis. This is a pure degenerative nephritis, manifesting itself at the end of a week or earlier by the presence of albumin and casts in the urine, usually in considerable quantity. This nephritis is almost constant after diphtheria, quite constant in all severe or late cases, causes diminution in the

(*Reprinted from International Clinics, Vol. I and II, Series 36. Published by permission of the J. B. Lippincott Company.)

amount of urine passed, but never dropsy or uræmia or even serious retention of nitrogen or chlorides in the blood. True inflammatory nephritis after diphtheria, with general œdema or uræmic symptoms, means either an error in diagnosis or a mixed infection and is not due to the diphtheria toxin. The form of nephritis which one sees almost constantly after diphtheria is purely toxic, with degeneration and desquamation of the epithelial cells lining the tubules. It does not cause marked symptoms and always disappears entirely in a few weeks, leaving no after effects. In many thousand cases observed in the Alexandra Hospital, Montreal, over a term of years, I can recall only a very few leaving the hospital with any signs of nephritis, and in all these there was reason to believe that nephritis was present before the diphtheria or was due to some other cause than the diphtheria alone. If the nephritis is so benign and transitory, is it of any clinical significance? Apart from influencing our treatment as regards diet during the first three weeks, I firmly believe it is of little importance beyond being a practical indicator of the amount of intoxication, and hence of what may be expected from the other organs.

One wishes devoutly that the same could be said of the next organ to be involved, almost simultaneously with the kidneys, and that is the heart, the commonest cause of death in the fatal cases of diphtheria. Cardiac failure after diphtheria has always attracted much clinical interest, and varied have been the opinions as to its cause. Thrombosis, paralysis and vasomotor failures have all been blamed, and it is only since the work of Warthin and others in this country within recent years that the condition has been placed on a sound pathologic basis.

We know now that the post-diphtheritic cardiac symptoms are due to an acute degenerative myocarditis. It is a toxic parenchymatous degeneration or necrosis of the muscle fibres of the heart, with a later reparative

inflammatory process with regeneration of the muscle. Both the contractile and conducting mechanisms of the heart may be affected by these processes. The occurrence of this myocarditis is apparently as constant as the nephritis, though it is harder to demonstrate. Only through change in the colour of the patient and the character of the pulse does one suspect its presence in mild cases. Blood pressure records help little, nor does the electrograph until the condition is well established. Cardiac dilatation with vomiting, heart-block or sudden death terminates the picture in the worst cases. The symptoms of myocarditis show themselves first on the fifth to the seventh day, culminate on the tenth to the fourteenth day, and rapidly subside, although it is several weeks before the heart returns to normal. Still, if the twenty-first day is passed, one should no longer fear absolute cardiac breakdown, if reasonable precautions are taken. It is of great interest to know what becomes of those severely affected hearts later. Are they permanently crippled, does the degenerative myocarditis lead to a fibrosis later in life? I can only say that I have been interested in following a number of the worst of these cases, which unexpectedly survived after being pulseless and with signs of cardiac dilatation, and in no single case was I able to demonstrate after one year that there was any disability whatsoever remaining, either by functional tests, physical examination or electrocardiographs. It is my firm belief that once the patient survives the acute attack there is absolute restoration of the heart to normal. I must confess that I am speaking only of children, and that it is possible that in adults the reparative power of the tissue may not be so great.

If, then, the outlook is so bright if the critical two weeks are survived, are there any therapeutic means of assisting the patient through this period? The only adjuvant I have any faith in is absolute physical rest,

in whatever way it may be secured. The patient should not be permitted to raise an arm from the bed; if vomiting begins, all nourishment by mouth should be stopped for two or three days. Morphine is given if there is any restlessness, though this rarely occurs until the case is beyond hope, but rather a lassitude and somnolence. Digitalis does harm by increasing the tendency to vomiting and heart-block, and other so-called "cardiac" stimulants seem of little avail. Remember always that it is only a few days to be survived and then the natural processes of repair will affect a cure.

The third clinical manifestation of the toxin, the effect on the nervous system, is always fascinating to watch. Until Walshe in England gave us the clue to these curious paralyses they seemed utterly irregular, purposeless and fantastic. Walshe showed clearly how the first effects on the nervous system were local, the toxin apparently passing along the local nerves from the site of the lesion to the central nervous system, affecting first the local nerves, then the neighbouring nuclei, and then the general nervous system as a whole. So in the ordinary pharyngeal cases of diphtheria there is first a paralysis of the soft palate, then two or three weeks later of the eyes and almost immediately after a weakness of all the body muscles, with loss of tendon reflexes. If the diphtheria occurred in a wound of the leg, there would be paralysis of the leg first. So constant is this sequence that I have more than once observed in cases of diphtheria of one tonsil only, that there was paralysis only of that half of the palate. The local paralysis is seen usually in the third week if closely looked for. The general paralysis begins about two weeks later with general weakness, paralysis of accommodation, squint, sensory disturbances and loss of reflexes. It culminates almost invariably at the end of six weeks, and then rapidly and steadily improves. The prognosis as regards life depends en-

tirely on the involvement of the diaphragm and muscles of respiration. Fortunately, these muscles are the last involved and their paresis is short lived. If one can keep the patient alive for a week, all symptoms will subside, for in this, as in all other toxic sequelæ of diphtheria, recovery is absolute and complete in the process of time.

In a typical case of diphtheria treated late with serum one observes the immediate improvement and subsidence of all the evidences of the disease, so that the patient appears convalescent. Then the quickly developing evidence of the later action of the toxin; the appearance of albumin, rapidly increasing in amount and later disappearing entirely; the progressive impairment of the heart, culminating in ten days, when the patient hovers between life and death for a few days, with subnormal temperature and almost imperceptible pulse; lastly, the paralysis beginning locally at the end of three weeks, becoming generalised in two weeks more, so that the patient passes through another critical period at the end of the sixth week, and barely survives a threatened respiratory paralysis, and finally recovers entirely, with apparent restoration to normal. These observations can be made in hundreds of cases, differing only in the degree of the various symptoms caused by the toxæmia. for, as stated previously, one of the most striking things about the effects of diphtheria is the uniformity of the symptoms caused by the action of the toxin.

If this progressive clinical observation is a true one, what practical lesson may be drawn from it? First and foremost, the importance of early treatment, of an adequate dose of antitoxin at the earliest possible moment, by a route through which it has the most rapid action, i.e., intravenously in all cases in which one has reason to suspect a dangerous dose of the toxin to have been absorbed.

Secondly, the need of close observation of the patient, noting first the albuminuria giving a rough measure of the intoxication; next, the evidences of involvement of the heart muscle, and, lastly, the progressive involvement of the nervous system.

The final lesson is the hope of the absolute restoration of the body to normal if the two brief critical periods can be survived; the one at the end of two weeks from cardiac failure and the other at the end of six weeks from respiratory paralysis.

Childhood and Tuberculosis

The last new thing in the realm of tuberculosis I will mention, and most important of all, is—children. The charm of children is their “surprisingness.” In the past few years there is a new light on tuberculosis in children, thanks to such men as McPhedran. We have long been hunting and hunting among adults for the early lesions and early stages of tuberculosis and have notoriously failed to find them. It is strange we have been so slow to see that some, at any rate, of the early lesions in an infected household would be most likely to be among the children, whose contacts are the closest contacts, and whose soil is virgin soil. Our ideas about children lagged a generation behind our knowledge about adults, chiefly because we had a single standard for measuring alike disease in the adult and the child. But the two types are almost two diseases, so different that they have little more than the causal organism in common. To use the terminology of syphilis, the *primary lesions* of tuberculosis are usually found in children, the secondary and tertiary usually found in adults. The very beginnings of tuberculosis are found commonly in children and more seldom in adults, and the more advanced stages are found commonly in adults and seldom in children. Diagnosis, treatment and prognosis all differ as between the young and the older. In the adult there are usually symptoms; in the child usually none, or slight, late and difficult to estimate. No single symptom is pathognomonic. Cough is as often absent as present. A plump appear-

ance does not rule out disease, nor does emaciation prove it. The stethoscope has little value. “By physical examination alone the most skilful examiner *cannot make a positive diagnosis* of tuberculosis in children; neither can he exclude it as a possibility—no matter what the appearance of the child.” (Chadwick).

The great *new light* of childhood tuberculosis is shed by the x-ray. Skilfully made films, carefully and thoughtfully interpreted, help more than all other means together to an understanding of the diagnosis, the course and the prognosis of the childhood phase. Plates in two planes are often needed, the postero-anterior and oblique. Now that we know better what the tuberculosis of childhood is our ideas of prognosis have changed. It is true that the adult type of tuberculosis in a child has a very bad outlook, but *childhood tuberculosis* in a child may have a very good outlook.

The discovery of the child in tuberculosis opens up a great new continent for exploration. It is in this new continent of childhood that the most fruitful explorations of the anti-tuberculosis forces will be made during the next generation. These sunrise people of a new day are always new, always fresh, always invite our quests, always more than repay what we can do for them. What we wish to do for the race must be done for the child. On their behalf we must even learn a good part of our tuberculosis all over again.

From *What Is New in Tuberculosis*, Dr. D. A. Stewart, C.M.A. Jn., January, 1932.)

Vacation Possibilities in New Brunswick

(Canadian Nurses Association General Meeting, Saint John, June 21-25, 1932)

New Brunswick can offer the visitor almost any type of vacation that is to be had, but it is generally assumed that when people come to the Maritimes for a holiday they wish to spend most of the time near the sea. Some, of course, may find pleasure on the inland lakes and streams and in the depths of the forest; others will want the "Country Club" life, with golf, tennis and the atmosphere of the big summer hotels. All of which is available in province.

For those who expect to attend the biennial meeting in Saint John in June, the following may be of help in arranging for a vacation visit in the province. No attempt is made to describe the numerous opportunities for delightful motor trips, but, rather, attention has been confined to the places where one may expect to stay for as long or short a time as is desired—and rest or play as the spirit so moves one.

Taking Saint John City as the starting point, and supposing vacation will not be counted on until after the meeting, we will work out the three directions, west, north, and east consecutively—south will take one across the Bay of Fundy to Nova Scotia, another province of limitless vacation prospects.

It is well for the visitor to the Maritimes to remember the historical importance of this section of our Dominion. The three maritimes and Quebec have bound up in their soil the earliest history of the country. Though there are no turreted castle ruins or magnificent cathedrals to mark the trend of time as in the older countries of Europe, yet there are stores of historic wealth with which we should be familiar and which should have a decided fascination for any Canadian. Tangible evidence does not always remain, because early buildings and forts were built of wood and most of them have long since returned to dust. However, one can find considerable

evidence in some places of the life that was carried on three hundred years ago, but best of all the beauty of the country is as unspoiled as when it first intrigued the gaze of the great explorers, Cartier, De Monts, and Champlain. New Brunswick is justly called "Canada's unspoiled province".

Starting in a south-westerly direction along the Bay of Fundy coast towards the State of Maine are several places where a delightful seaside vacation may be had. The road is excellent, and one may travel, if one's own car is left behind, by bus, although the bus will not take one off the main trunk road into several of the quaint little fishing villages, chiefly Lorneville, Dipper Harbour, and Mace's Bay, reminding one of the old world coast of Scotland or France.

At New River Beach, about 20 miles from Saint John, you will find one of the finest stretches of white sandy seashore on the north Atlantic coast, and here you may hire a log cabin or a house nestling against a background of pines and firs, and facing the wide sweeping waters of the Bay of Fundy. You can watch the magic of old Fundy's tide twice a day, bathe in the stinging salt water (they say it "steps up" metabolism), have bonfires on the beach, and if the moon and tide are high at the same time, the sheer stark beauty of it will quite take your breath. You will be left with a picture of sky, water, rock, sand, and trees so blended that you will never forget it. Perhaps some old "four-master," with sails all set, all gold, under a brilliant moon, will appear out of the horizon, a rare sight in these days, to add one more perfect touch to the picture. There are two log cabins accommodating five persons each, and one house for six, and all you need is your food. There are fireplaces for the days when Fundy's fog will make you seek inside warmth. There is also a Tea Room where meals may be

had. The cabins can be rented for any length of time.

For those who do not want a seashore holiday, on this same route, fifty miles from Saint John, is a charming fresh water lake, Lake Utopia. Here there are inviting stretches of sandy beach, bathing, canoeing, boating and fishing. Camps may be rented, and if desired, meals had at a central dining room or prepared in camp. This takes one off the beaten track into a section of exquisite inland scenery.

Continuing on this same route, we pass through the village of St. George and on to St. Andrews-by-the-Sea. This is the popular summer resort made famous by the C.P.R. Hotel Algonquin and the many magnificent homes of the wealthy summer residents. Golf, tennis, bathing and boating may be had here. The scenery of the island-dotted Passamaquoddy Bay presents an ever-changing picture, and you will want to visit Deer Island and Campobello Island. St. Andrews itself is a delightful old Loyalist town. There are many things of historic interest to see: the old Block House, the Greenwich Kirk, and the quaint old houses of soft, low, beautiful lines, such as marked the simple taste of our Loyalist forefathers.

The fishing weirs that dot the coast line all about the Bay are always of interest to the "land lubber": these are used to catch sardines, the chief industry of this section of the province, and the largest sardine-canning factory in the world is at Black's Harbour, a little further up the Bay.

Following this same route we come to the St. Croix River, marking the boundary between Maine and New Brunswick. This river has a point of considerable historical interest. Watch out for the little island with the lighthouse and you will see what is now called Docket's Island, the very one where Champlain in 1504 and 1505 spent his first winter in Canada, and where he lost 35 of his 79 men from scurvy. In the 18th century the skeletons of those buried on the

island became exposed by the erosion of the sea and the spot became "Bones Island". Coming to St. Stephen we find the International Bridge, and across the river the United States town of Calais.

There is always a fascination to living on an island, especially an island in the sea, and if you would like to have this experience, Grand Manan, situated at the mouth of the Bay of Fundy, nine miles from the United States coast, can offer all the thrills that your imagination built around your first geography lesson on islands. This is a favourite vacation resort, offering natural scenic beauty and a strong, healthy climate with freedom from hay fever. There are many points of geological interest in the peculiar rock formation of this island. It is twenty-one miles long and nine miles wide. Boating, bathing and fishing provide plenty of holiday entertainment. To get to Grand Manan one takes a motor ship from Saint John and is able to enjoy a refreshing salt water sail of several hours either direct or through the beautiful Passamaquoddy Bay region, depending on the day of sailing. Several small lakes on the island will give you a chance to try your luck for speckled trout. Hotel and private home accommodation may be had.

The next route we will follow is along the Saint John River, going in a northerly direction to the centre of the province. This river is the largest between the St. Lawrence and the Mississippi, and is popularly known as the "Rhine of America"—not because it actually resembles the Rhine, with its peaks and bluffs topped by old robber baron castles, and its steep, grapevine-covered slopes, but because it is equally as beautiful in a very different way. Here you will find inland scenery unsurpassed—soft, rolling hills on which are prosperous farms, stretches of sandy beach such as one rarely finds inland, tributary lakes and rivers, each one a gem in itself, luscious grassy intervals and small wooded islands. One can really

only know the river by travelling in canoe with a tent for a house.

The world-famous Reversing Falls at the mouth of the river attract thousands of tourists each year. Putting aside the explanation in the forces of nature which produce this phenomena, here is the Indian legend of the formation of the Falls: Glooscap, one of the Indian gods, had control of the animals as well as the Indians. Big Beaver was not behaving in the Passamaquoddy district, and Glooscap went after him. Big Beaver fled and built a huge dam across the mouth of the river flooding the whole country back of it and making a huge lake. When Glooscap saw the dam he smote it with his mighty club. A piece floated out and became Partridge Island at the entrance of the harbour, and the split rock below the Falls is Glooscap's club, which he threw away after smashing the dam. The big lake disappeared, leaving only what is now Grand Lake, the largest lake in the province.

The best way to see the Saint John River is to take the steamer at Saint John and enjoy a day's trip to Fredericton, where the steamship line ends. If you have a car, the river road to Fredericton makes a magnificent motor trip, and lunch can be had at one of several places en route. Steamers also run to the head of the two largest lakes, Washademoak and Grand Lake, which is 30 miles long. Hotel accommodation can be had at the head of these lakes.

A week-end in Fredericton, the capital of New Brunswick, will well repay one. There is much of interest here. This small, tree-shaded city, with its perfect little cathedral, parliament buildings, University of New Brunswick, Normal School, Old Government House, fine homes and beautiful gardens, has a decided charm of its own.

Following further up the river one must travel by train or car. At Perth very comfortable log cabins with every convenience may be had, and one may stay as long as good food, the rushing

river (it is much narrower here, with a swifter current), the green hills, and the sounds that go with farming in June, hold you.

At this point on the river, if you have a car and you wish to lose yourself completely to the world, arrangements can be made for accommodation near the head waters of the Tobique River, one of the most famous salmon-fishing rivers on the continent. It is a fascinating motor trip along the Tobique from Perth to Riley Brook, where you are 30 miles from the nearest railway point.

Going back to Fredericton again, instead of continuing up the Saint John River, we cut diagonally across the centre of the province in a north-easterly direction, following first the lovely Nashwaak River, and then meeting the head waters of the Miramichi at Boiestown. Here you are in the heart of the big game country: comfortable camps may be had here, with central dining-room service, and you may go salmon-fishing if your purse and muscle will permit indulging in the "King of Sports". The route along the Miramichi is through densely wooded country, weaving back and forth across the river, and running for miles through stretches of unsettled forest, then coming out at small villages in sight of the river, until finally you smell the bracing salt sea again, and you have come out on the east coast and the Gulf of St. Lawrence.

At Newcastle you may take two ways of getting to the Bay Chaleur. One way is to follow along the coast until you come to Caraquet, where good accommodation is to be had and where you can enjoy a complete rest watching the fishing fleets come and go, and the life of the quaint little French fishing village. The other way is straight north through the maple and birch woods to Bathurst on the glistening Bay Chaleur. There is not a more beautiful and entrancing stretch of water in the world. The many-coloured hills of Quebec, the continually-changing sky line, and the

magnificent sunsets create a panorama of which one never wearies. It was Jacques Cartier, sailing into the Bay in 1534, after coming through the icy blasts of the Gulf of St. Lawrence, who gave it its charming name. Looking on its peaceful beauty one can hardly believe that near Campbellton the hills once echoed and re-echoed with the last naval battle of the Seven Years' War in America.

At Youghall Beach, a short distance from Bathurst, is another of those flawless stretches of seashore which seem to have been made to lure many from the workaday world and tempt them to lounge forever on the dry, white sand and listen to the hypnotic pounding of the surf. Add to that, sea water of extraordinary high temperature, and you have a combination of nature's gifts hard to equal. Accommodation may be had at two farm houses only, as the camps and houses are otherwise all privately owned.

There are many attractive villages on this coast on the way from Bathurst to Campbellton at the head of the Bay, and a few of these cater to vacationists. One especially popular place is Jacquet River, and this year accommodation may be had at Petit Rocher also. There is excellent bathing all along the bay. When Lord Byng was travelling through this section of the country, he had his train stopped for two days at New Mills because the scenery of the Bay so captivated him.

Before coming to Dalhousie, a little town built on the face of a steep hill, and now the site of one of the biggest pulp mills in the country, one should stop and inspect the beach at Fossil Cove. Here can be found fossil corals, sponges, etc., showing that a warm sea existed here thousands of years ago.

The Bay now suddenly narrows, and at Campbellton, nestling among high blue hills that remind one so of Scotland, one comes to the mouth of the Matapedia River. Fifteen miles farther up this magnificent river, where the Restigouche River coming down from the depths of the virgin forest

meets it, you say *au revoir* to New Brunswick and *bon jour* to Quebec. (This is the route out of New Brunswick for the Gaspé coast.)

The third and easterly route out of Saint John takes you through the Kennebecasis River valley and into one of the most fertile sections of the province, with splendid farms on all sides, some of them dating back to the time of the Loyalists. Coming to Moncton one finds a busy railway junction city, and it is from here if you are travelling by train or car that you will start on the road to Prince Edward Island, or Nova Scotia. You will want to see the tidal bore on the Petitcodiac River, at the head of the Bay of Fundy.

On the Straits of Northumberland, about fifteen miles from Moncton, are some famous beaches at Point du Chene. Excellent hotel accommodation can be had at Shediac, about two miles from the best of the bathing beaches. Conveyances to and from the beaches can readily be obtained at the hotel.

The short neck of land which joins New Brunswick and Nova Scotia, the Isthmus of Chignecto, is especially interesting because it was one of the earliest French settled sections of old Acadie. In the struggle between France and England to gain possession of the country forts were built by both sides, and today the remains of old Fort Beausejour (later Fort Cumberland) are well worth inspection.

And so, if you wish, you will continue your journey from here to the "Island" or to Nova Scotia, but the New Brunswick Registered Nurses Association hopes that you will spend most of your vacation here in this province, and offers you the warmth of a real "down-east welcome," and is glad to answer any enquiries or make arrangements for those attending the Biennial, at any time.

Kindly communicate with Miss H. Dykeman, Chairman Transportation Committee, Health Centre, Saint John, New Brunswick.

ACCOMMODATION AT VACATION SITES IN NEW BRUNSWICK

(This does not include hotels in towns and villages en route.)

BAY OF FUNDY DISTRICT

NEW RIVER BEACH: Cabins.....	2 cabins for 5, \$30 a week.
Miss Nora Knight, Rothesay Collegiate School, Rothesay, N.B.....	1 house for 6, \$35 a week.
LAKE UTOPIA: Bryn Derwyn Camp.....	Main camps, room and board, \$4 a day.
Jas. W. Brine, St. George, N.B.....	Other camps for 5-7 people, \$5 to \$6 a day.
ST. ANDREWS-BY-THE-SEA:	
Algonquin Hotel.....	Single rooms with bath, \$11 to \$16 a day.
	Double rooms with bath, \$10 to \$11 a day.
	Single rooms without bath, \$10 to \$12 a day.
	Double rooms without bath, \$9 to \$10 a day.
Kennedy House.....	\$4 a day and up; \$28 to \$35 a week.
Seaside Inn.....	\$3.50 a day; \$15 a week on third floor.
	\$18 to \$21 a week on second floor.
GRAND MANAN:	
Rose Cottage.....	\$2.50 a day; \$10 to \$18 a week.
Swallow Tail Inn.....	\$3.00 a day; \$13 to \$15 a week.

SAINT JOHN RIVER DISTRICT

WOODMAN'S POINT: Miss Inches.....	\$15 a week (20 miles from Saint John).
MORRISDALE: Mrs. F. K. Reynolds, 20 Millidge Ave., Saint John, N.B.....	Camps with central dining room, \$1 to \$1.50 a day—Meals a la carte.
GRAND LAKE: Chipman—Chipman House.....	\$3 a day; \$15 a week.
WASHADEMOAK LAKE: White House Inn.....	\$3 a day; \$15 a week.
FREDERICTON:	
Queen Hotel.....	\$4 to \$5 a day (American Plan).
Barker House.....	\$4 to \$4.50 a day (American Plan).
Windsor Hotel.....	\$3 to \$3.50 a day (American Plan).
PERTH: Ann's Tea Room, c.o. A. A. McLaughlin, Perth, N.B.....	Room in cabins or main house, with meals, \$3.50 a day.

MIRAMICHI DISTRICT

BOUESTOWN ON THE MIRAMICHI: The Griffin House, Wm. F. Griffin, Boiestown, N.B.....	\$2.50 a day (cabin and central lounge and dining room, including meals).
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BAY CHALEUR DISTRICT

CARAQUET: Sea Gull Inn, Miss Josephine Rive.....	\$2.50 a day; \$14 a week.
YOUGHALL BEACH:	
Miss Armstrong.....	\$13 a week.
Mrs. Kerr.....	\$12 a week.
BATHURST:	
Carleton Hotel.....	\$3 and \$3.50 a day; \$12 and \$15 a week.
Gloucester Hotel.....	\$4 and \$4.50 a day.
PETIT ROCHER:	
Miss G. Louise Burns, Bathurst, N.B.....	Accommodation for 6 persons, \$3 a day; \$15 a week.
JACQUET RIVER: The Bay View Inn, Paul Doyle, Esq., Jacquet River, N.B.....	\$18 to \$20 a week.



Reversing Falls, Saint John, N.B.



Admiral Beatty Hotel, Saint John, N.B.

The Admiral Beatty Hotel will be headquarters for the Sixteenth General Meeting of the Canadian Nurses Association. The management has placed at the convenience of the Association Floor II of the Hotel; this

arrangement provides accommodation for general sessions in the well-appointed ballroom, for section sessions and committee meetings in smaller rooms, for the exhibits, both professional and commercial, as well as registration and information desks, all on the same floor. It is hoped that all delegates and visiting nurses will find it convenient to be guests at the Hotel during convention week, where they will be assured excellent service from the hotel staff.

Reservations for accommodation should be made early. The hotel rates per day are: Single room without bath, \$3.00; Double room without bath, \$5.00; Single room with bath, \$4.00, \$4.50 and \$5.00; Double room with bath, \$6.00, \$7.00, \$8.00 and \$9.00. Additional persons in room, separate bed, add \$2.00. All rooms have hot and cold water and toilets.

Nurses are advised to state when making reservation that they are members of the Canadian Nurses Association.

Reservation should be made to Mr. E. B. Sweeney, Manager, Admiral Beatty Hotel, Saint John, N.B.

The Anglo-Yugoslav Children's Hospital

By FRANK YEIGH, Toronto

Few people probably realise the radiation of nursing services, especially during a war. A striking example is afforded by the Anglo-Yugoslav Children's Hospital, in Belgrade, the capital of that country of over ten million people.

It is a stirring tale of a carrying-on policy on the part of some of the nurses who served in the Serbia of pre-war days, and especially during the Serbian retreat of mid-winter, amid scenes that, although now largely forgotten, yet remain among the most terrible of all. Many Canadian nurses served in this wonderful war service and, naturally, returned to Canada after the Armistice. A few remained, however, not only from Canada, but from the British Isles, notably Dr. Katherine S. Macphail, a graduate of a Scottish University, who, realising the continued need for nursing service for the children, started largely on faith a hospital in Belgrade. From the start it was assisted by the noble Save-the-Children Fund as one of its benefactions on behalf of needy women and children in a score of countries, regardless as to whether they were allied or enemy.

Today there stands a striking building in the heart of Belgrade as the only exclusively children's hospital in that country, and the fame of which has gone far afield, so that it is frequently visited by medical deputations from other European countries. Starting in 1919 with poor equipment and accommodation and with only a handful of little patients and an assisting nurse or two, over a hundred thousand children have passed through its books, either as out or in-patients. What it has meant to the suffering little ones of that land cannot be recorded or realised. The

broken-down barrack-hospital of twelve years ago is now better housed and is largely supported by the Serbian Government, although a further five thousand dollars is needed from voluntary offerings to carry on its work efficiently. The administration is still in the hands of Dr. Macphail, in close co-operation with the National Ministry of Health, and the Queen is an active supporter.

The writer visited the hospital and was thrilled with the work being done. Every one of the sixty cots was occupied by relatively happy patients drawn from all parts of the country, and under the care of a well-trained staff, mostly Serbian. He will not soon forget, however, the scenes at the out-patients' quarters, where early in the morning peasants came in large numbers, sometimes from long distances and on foot or on pony back with their sick charges, forming a most helpless and hopeless looking gathering of humans, in striking contrast with the cared-for ones in the adjoining wards. The gratitude of the parents was touching in the extreme, and one felt proud that here in this comparatively distant and partially unknown land, the kindly beneficence of friends far away and the unselfish service of a Scotch lady doctor were transforming lives by the hundreds, indeed the thousands.

Provincial Nurses' Associations in Canada have from time to time had a share in this splendid welfare work by making small grants, and if any others, as associations or individual members thereof, would like to share it, the Save-the-Children Fund, through its Canadian Committee, will be glad to act as almoners, of which the writer is the Canadian representative, at 588 Huron Street, Toronto.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,

Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

Methods of Teaching Chemistry

By NORENA S. MACKENZIE, Assistant Instructor, School of Nursing,
Montreal General Hospital, Montreal

Nursing is an art which receives its dicta from science, hence science subjects have been included in nursing curricula. Parallel with the evolution of medicine has come a nursing service, which daily grows more detailed; and the rapidity with which metabolism research has grown, and the therapeutic use of biological products, has increased the number of teaching hours in schools of nursing.

The teaching of chemistry in schools of nursing is not simply to add to the number of teaching hours, nor an attempt to teach student nurses much about chemistry itself in a comparatively short space of time. It is included in the curriculum to emphasize and, if possible, to cultivate an appreciation of the necessity for accuracy in observation and description, and to assist in the explanation of subjects of which it is the basis.

If chemistry has not been included in the educational programme of students anticipating entrance to a school of nursing, they would be prone to find a short, intensive course confusing and almost beyond their comprehension in detail, if it were not taught by one whose thorough knowledge of the subject permits of great simplicity in teaching and a fine appreciation of its relationship to other subjects in their course.

It is the duty of a school to give its students a balanced course of study. The position a subject holds in any curriculum depends upon its contribution to the ultimate object of

that form of education, and as the ultimate object of a nursing curriculum is to graduate nurses who will render intelligent care to their patients, chemistry, among other sciences, has been included in the course of study in order that the nurse may have a greater comprehension of the value of such subjects as dietetics, materia medica, metabolism, bacteriology, physiology, and urinalysis.

The teaching of chemistry produces problems in many schools. Frequently the greatest difficulty is that the nurse-instructor is not qualified to teach the subject and often there is no properly equipped laboratory, or at best a poor makeshift. In the event of the former, there are many sources within the hospital from which co-operation may be obtained, viz.: the dietetic department, the dispensary, and interne, or perhaps if especially favoured as we, one of the staff of the metabolism department may agree to teach the course. It is preferable that the instruction comes from one within the hospital, because he has a finer sense of the application of chemistry to nursing. However, if that be impossible, the instruction may have to be obtained from local high or technical schools. Many hospitals, if favourably situated, send their students to the university for chemistry, where they receive a splendid course from professors who appreciate their needs.

The number of hours available for teaching chemistry is invariably a

difficulty. In the school for nursing in this hospital, as well as many others, thirty hours have been allotted to this subject, consisting of ten hours of lectures, each followed by a two-hour laboratory period. Fortunate are they whose teaching unit includes a science laboratory, because then there is no problem of fitting in the period most suitable for the student nurse which will not encroach upon the time of the students or internes whose laboratory is being used, as is often the case when a hospital laboratory is the only one available. If the student nurse is sent to the university for chemistry the difficulty is solved, but it still remains a problem for the school which has no access to a university nor a hospital laboratory. In that event it may be possible to obtain the use of the high school equipment. From whatever source the equipment may come, it is essential that the student perform her own experiments. If she be a spectator only her interest lags, and certainly it is not conducive to acute observation, nor is she likely to attempt to formulate any conclusions of her own.

A thorough preparation for the course involves a careful outline of each lecture and laboratory period. It has been found very beneficial in this school to give each student a printed detailed outline of each laboratory period, because, first, those to whom the subject is new will follow more accurately; second, it eliminates the waste of time in dictating the procedure and the possibility of inaccurate copying by the student; and, third, it forms a compact synopsis of the en-

tire laboratory work for future reference. Devoting a short time at the end of each laboratory period to summarising what has been done and pointing out its relationship to other subjects will give the student a clearer vision of its purpose. In order that the laboratory supervisor maintain a definite correlation between the lecture and the experiments, she should attend the lectures with the students; and if there be a large number in the class to whom chemistry is a new subject, it is unwise to attempt supervising too numerous a group.

Most schools prescribe a text for supplementary reading. There are many good books on chemistry for nurses, among them:

Principles of Chemistry and Their Application (Bartlett & Ink, 1927).

Outline of Chemistry: Sister Domitilla (1930), which is a student's work book as well.

Essentials of Chemistry: Luros (1929).

Applied Chemistry for Nurses: Goos-tray-Karr.

Fundamentals of Chemistry: Bogert (2nd edition, 1928).

Chemistry for Nurses: Peters (1923).

When the lectures and classes dealing with carbohydrates, fats, and proteins are being studied, the student may be asked to review the physiology of the digestive system, and also be assigned reading in books dealing with dietetics and nutrition.

It seems that no course is complete without an examination. This may be written or practical, or both. But whatever form this takes, its main objective should be ascertaining the students' ability to appreciate those points bearing a direct relationship to nursing.

THE SURVEY REPORT IS PUBLISHED

The Report of the Survey of Nursing in Canada by Dr. George M. Weir is ready for sale. Copies may be obtained through the secretaries of provincial associations, through the National Office, 511 Boyd Building, Winnipeg, or from the University Press, University of Toronto. The price is \$2.00 for single copies or \$1.75 in groups of ten. The reason that the lower rate can be given in groups of ten is because of a saving in postage. Those who wish to purchase the Report are reminded that provincial associations are desirous of selling as many copies as possible and will appreciate their members applying to the secretary of the provincial organisation to which they belong.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,

MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

The Mental Health Clinic

By Dr. S. R. MONTGOMERY, Whitby, Ont.

For a long time we have realised the need and great good that has resulted from the practice of preventive medicine. Our boards of health are well established in all large centres, and more and more we find the smaller communities demanding better facilities for combating and preventing the spread of disease. We have long hoped that these hygiene methods would spread to the mental field, for it is well known that we cannot separate mind from body. So that a year ago, when the province of Ontario established its mental health clinics, we, who are in psychiatry, felt that we were making a great advance in medicine.

May I justify this establishment of mental health clinics. Each year in Ontario there are roughly 2,000 admissions to mental hospitals. Of this number, something over 400 are admitted to the Ontario Hospital at Whitby. These mentally ill persons are in the community an average of one to three years with little or no treatment before admission to hospital. Of our three million population it is estimated that 7,500 are mentally deficient. Our one hospital at Orillia, especially adapted to the care of this latter group, has accommodation for 1,500 persons, and, as well as always being filled to capacity, has a constant waiting list of about 1,100 names.

We all realise the need for good physical health, and even greater is our need for good mental health. Our whole happiness depends upon it. Dr.

Hartwell, in his recent book, "Fifty-five Bad Boys," has well summed up when he says, "In the final analysis the behaviour of all human beings, both children and adults, is their attempt to gain happiness. All their behaviour and their mental life is, as far as they are able to control it, a striving toward this end. Unless one understands the child in this desire for happiness one does not understand him at all." How must we gain and maintain this happiness or mental health? By facing squarely all life situations and dealing with them adequately.

For a long time our provincial institutions were considered places of incarceration only. The name "asylum," though originally spoken in a kindly way, for it means place of refuge, took on a harsh sound and was spoken with sadness or jest. Fortunately, we have changed the name to "hospital," for hospital means "place of treatment," and gradually the old prejudice is being broken down and more people are being brought to hospital. Whereas, formerly, mental patients were hidden lest they be placed in asylums for incarceration, now they are being brought to mental hospitals by family and friends for treatment. When one realises that at Whitby 60 per cent. of admissions go home each year, it is readily understood why the general public feeling is changing. This change in feeling no doubt partly accounts for our increased admission to mental hospitals.

With this as a background, may I now enlarge on the clinic, its activi-

(A paper read before the Alumnae of Nicholls Hospital, Peterborough, Ont.)

ties and policies? One clinic group now works out of each Ontario hospital, and is made up of a psychiatrist, a social worker, a psychologist, and a secretary. We attempt to cover our respective hospital areas. Our duties are four-fold:

- (1) We do psychiatric follow-up work for the hospital; that is, as patients leave hospital we aid them in re-establishment in the home, in the community, and occupation.

- (2) We do field studies of the mental defective problem in certain areas.

- (3) We supervise and treat certain government wards (defectives) in the community.

- (4) We act as an out-patient child guidance clinic to serve schools, juvenile courts, children's aid societies, social agencies, and penal institutions.

In other words, we are a travelling social adjustment clinic.

Our Whitby clinic now regularly visits Oshawa, Lindsay, Peterborough, Port Hope, and Cobourg, and we have arrangements under way to hold regular clinics in Whitby town library. It is my desire to make clear to you that although we are seeing psychotic, prepsychotic and mentally defective persons, that our main object is to see any adult or child who has a social problem of any sort. We, as educated persons, must break down the prejudice that accompanies the voicing of a suggestion that anyone needs mental care. Let us remember that social adjustment is our object. Social adjustment aids in the striving after happiness, and happiness means mental health.

May I outline some of the problems that make for social maladjustment? In the school there is the pupil who is not adjusting properly to his school work, his contacts with his fellows or with his teacher. There are those in whom the natural fidgetiness of childhood is over-accentuated, those who are a constant source of worry because of misbehaviour, those whose work is passable except in one especial subject. Of course, a certain amount of self-analysis is necessary

before we can understand the classroom reaction of children, for we must always look for the good in children. A child is only as good as we expect him to be, and distrust breeds bad behaviour. I was dumbfounded not long ago on learning one teacher's attitude toward children. She said while talking of a certain boy who was a problem in her class, "Of course, after fifteen years of teaching I realise how much bad there is in children." Naturally this attitude was just the type of one to invite misbehaviour.

Part of our examination is a thorough physical one. It is indeed surprising the amount of physical abnormality that may be overlooked and the resultant difficulty misinterpreted. I think of one boy who was constantly being criticised at home, at school and line because of his posture. It had become so severe that he had few peaceful moments and was in consequence developing a paranoid type of reaction, with bad behaviour as a result. We found on examination a definite curvature of the spine that made it impossible for him to stand or sit perfectly straight. This difficulty was explained to both teacher and parents; the boy was no longer criticised and he began to feel that he could go about without this constant nagging, so that gradually his whole attitude has changed. He has improved in his school work and his behaviour is better.

Another boy, because of physical deformity, had begun to wet himself. He became very much upset about this, became withdrawn, would not play with the other children, and gradually as inattentiveness increased the quality of his school work dropped off. After the clinic had seen him and had arranged for a slight operation he lost his feeling of insecurity and inferiority and began again to take an active interest in sports and especially in his school work. He now stands well up in his class.

Still another boy was found to suffer from badly infected tonsils, which

were constantly discharging pus. This boy following operation changed in disposition and improved in his studies so that he stood sixth in his class. At normal school attention is drawn to difficulties in vision and hearing. I fear that sometimes these difficulties are forgotten, for several children lately when found to have poor sight or hearing have been placed near the front of the classroom and have surprised their teachers by their improvement.

The physical side of a child's make-up is vastly important, but there are other factors to be considered too. In the classroom the teacher sees only one side of the child's life, but all the rest of his life outside of school colours his schoolroom reaction. We in the clinic attempt to get a long section picture of his whole life, his home, his school and his play. More and more we realise the important part that environment plays; broken homes, quarrelling parents, realisation of poverty or financial difficulty in the home, all these things go to make for feelings of insecurity in the child. Inferiority, too, is developed by comparison; one child smarter than the other in the parents' opinion and that constant remark, "Why don't you do as well as your sister or your brother?" The child who is considered the best in the class because

he stays in at recess to work for the teacher may really be running away from the necessity of meeting the other children at play. This usually is a way of not facing life's situations squarely and not facing them adequately.

Then a word about speech defect. We at last have learned that children must be taught to talk. But unfortunately even yet many educated people do not realise this fact, and what a source of insecurity and inferiority this difficulty of faulty speech can present to the child. Speech defect makes him timid, self-conscious and shy, and in consequence his school work and his social reaction is inadequate.

Time will not permit me to further enlarge on the type of difficulties which we hope to aid. Suffice it to say that in all fairness to our school children, any retardation or behaviour difficulty in the classroom should be carefully investigated, and any problem in adult life that lends to social maladjustment and consequent lack of happiness also demands of us careful investigation. It is our wish in the mental health clinic to work with physicians, nurses, teachers and all social agencies to aid in the establishment of mental health in all that come to us; in other words, our greatest desire is *happiness for all*.

THE VICTIM

"The law of heredity winds like a red thread through the history of every criminal, of every epileptic, eccentric and insane person."

AUGUST FOREL, M.D., Ph.D., LL.D.

I did not sow myself this thing that I must reap,
Or bind the sheaves that make my load.
Tillage of rotten soil has claimed its debt,
And someone dared to hew for me the songless road.

Someone who breathed before me will face God's rebuke
(His tender eyes will anger when he speaks of me),
And I shall rise from out a madman's grave to cry
Shame on the lust that cared not for the lives to be!

V. V. R.

Employment for Nurses

Some time ago a request was made to the secretary of each provincial association of registered nurses, in an effort to obtain for the *Journal* an account of what is being done in each province to assist in relieving unemployment among nurses.

The Secretary of the Association of Registered Nurses in the Province of Quebec has contributed the following report:

There is very considerable unemployment among nurses in Quebec Province, but no section carries the serious problem in this regard as does the group in Montreal, where the daily average of unemployed registered nurses for the past year has been over four hundred. In an effort to overcome this unhappy situation, all hospitals throughout the province are endeavouring to take care of their own graduates, and no nurse is occupying a position unless she is obliged to earn her living. The Montreal Graduate Nurses Association, operating the Central Registry, has been conducting a loan fund for members for nearly two years, and every effort is being made to provide an even distribution of calls, so that all those registered for duty may share equal opportunities.

Several of the French hospitals are employing graduate lay nurses on their staffs, for the first time, and others have increased their numbers.

All English hospitals have increased the number of graduates on their staffs, especially in private wards.

One hospital has provided a scheme whereby their graduates may do hourly nursing on the hospital staff, fitting in where duty is heaviest, thus assisting the individual nurses and the hospital administration.

In another, for the past two years, the student nurses have been withdrawn from the private wards and graduates only employed: graduates are also engaged for various phases of night duty.

A third hospital is providing increased general ward duty for its graduates, funds for which have been supplied by the members of regular hospital nursing staff (large in number), who are each contributing one day's salary per month for a period of six months, to be increased if necessary. The amount realised in this way will prove to be very considerable, and the number of nurses given at least a limited amount of duty quite large.

In a fourth, the Board of Management is co-operating most sympathetically with the unemployment situation by having given the Superintendent of Nurses *carte blanche* to increase the graduate nurse staff whenever and wherever advisable. This hospital, having considerably increased the number of student nurses in affiliation for special courses during the past year, is replacing vacancies caused thereby with graduates instead of increasing the number of the student group. A special effort was also made in this hospital at Christmas time to place as many out-of-town nurses on duty in the hospital as possible, so that they might share the Christmas spirit. This hospital has also created a special fund from which graduates may obtain loans if they desire.

The special hospitals, viz.: obstetrics, pædiatrics and communicable diseases, have materially increased the number of graduates on general duty.

ANNUAL MEETINGS

Alberta Association of Registered Nurses, Edmonton, March 22nd and 23rd, 1932.

Saskatchewan Registered Nurses Association, Saskatoon, March 31st and April 1st, 1932.

News Notes

ALBERTA

The annual meeting of the Alberta Association of Registered Nurses will be held in Edmonton on March 22 and 23, 1932. Miss Jean E. Browne, Director of Canadian Red Cross, will be the guest speaker.

BRITISH COLUMBIA

VICTORIA: The annual meeting of the Victoria Graduate Nurses Association was held at St. Joseph's Hospital Nurses Home on February 2, 1932. There was a large and representative gathering present. After the usual monthly business was dispatched, the yearly reports were read, and these were found quite encouraging, considering the financial depression and the unemployment situation. A hearty vote of thanks was tendered the local hospitals for their kind hospitality throughout the year. A committee was appointed to arrange for some more tangible way of showing the appreciation of the Association for this courteous hospitality. A Kardex system has been installed by the Association, which, it is hoped, will facilitate the handling of the Registry. At the close of the meeting a pleasant social hour was spent and dainty refreshments were served under the convenship of Miss Ellen Cameron. The officers for 1932 are: President, Miss Meta Hodge; First Vice-President, Miss Eunice Milloy; Second Vice-President, Miss Dorothy Frampton; Secretary, Miss Estella Herbert; Treasurer, Miss Winnifred Cooke; Executive, Misses Ethel Morrison, Frances Hooke, C. M. Kenny, Helen Cruickshank, Ellen Cameron; Sick Benefit Convener, Miss C. M. Kenny.

The sincerest sympathy of the Association is tendered to Miss Gertrude Curry, of the Royal Jubilee Hospital staff, in the loss of her father.

MANITOBA

ST. BONIFACE HOSPITAL: At the annual meeting of the Alumnae Association, held in the Nurses Residence, the following officers were elected: Hon. President, Sister Mead; Hon. Vice-President First, Sister Krause; President, Miss E. Shirley; First Vice-President, Miss E. Perry; Second Vice-President, Miss H. Stevens; Secretary, Mrs. Stella Gordon Kerr; Treasurer, Miss A. Price. The Alumnae held their annual social benefit evening in the Picardy Salon, Winnipeg, on February 8, 1932.

At the February meeting of the Alumnae, held in the Nurses Residence, lantern slides were shown on "The Preparation of Serum". This was followed by a very interesting and instructive talk on Cancer and Radium, by Dr. R. W. Richardson.

BRANDON: The Graduate Nurses Association met on February 6th, at the home of Mr. E. Fotheringham. The programme was under

the direction of the Married Nurses' Group. A number of business items were disposed of and a very interesting and comprehensive account of the recent convention of the Manitoba Association of Registered Nurses was given by Miss Eva McNally. This was followed by a pleasing paper on Dresden china given by Mrs. B. E. Hull. During the social hour a pleasant feature was the presentation of a basket of flowers to Mrs. S. J. S. Peirce, whose birthday it was.

NEW BRUNSWICK

CHATHAM: On the evening of January 14th the Nurses Alumnae of the Hotel Dieu School of Nursing gathered at the hospital for a pleasant "At Home," to which they had been invited by Mother Superior and the nursing staff. All those whose duties would allow accepted the invitation, and at 8 p.m. a fairly good number took part in the business meeting, at which officers for the coming year were elected: President, Miss Clara Skidd; Vice-President, Miss Florence Fitzpatrick; Secretary, Miss Annie Hill; Treasurer, Miss Olive McBride. Following this meeting, those present adjourned to the Seniors' reception hall of St. Michael's Academy, where arrangements had been made for an enjoyable evening, featured mainly by music, vocal and instrumental. The social hour was opened by Reverend J. F. Ryan of St. Thomas College, with an excellent speech on the significant characteristics of an Alumnae in relation to its Alma Mater. In extending a vote of thanks to the speaker, Mrs. J. McMahon, the retiring president, addressed a very earnest appeal to Father Ryan to accept the office and duties of Spiritual Adviser to the Alumnae of Hotel Dieu, which request was most graciously acceded to.

The Alumnae deserves much praise for the very tangible way in which it expresses its loyalty to the hospital and school. This is evidenced by the many little gifts of practical utility that so frequently find their way to the departments of the hospital. Recently the Children's ward was opened, and in a remarkably short time the empty room was changed into an attractive ward for five children. A metal tablet on the ward door informs the passing visitor that this was the work of the Alumnae of Hotel Dieu.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in February, 1932, were 902, fifty-two less than in January, 1932.

APPOINTMENTS

GENERAL HOSPITAL, HAMILTON: The Misses Daisy Hamilton (1929) and Olive Phillips (1930) have accepted positions on the staff of the Infants' Home, Hamilton. Overseas Sister Catherine Irwin is on the staff at St. Peter's Infirmary.

CHATHAM: Miss Viola Dyer, as Assistant Superintendent of the Public General Hospital, Chatham, following Miss D. Thomas' resignation.

ONTARIO DEPARTMENT OF HEALTH: Miss Maude Weaver, 1931 graduate of Course II, Public Health Nursing, University of Toronto, is doing public health work in Chapleau. Miss Weaver has just completed a month's work in the schools of Orangeville.

Miss Joan Coutts (St. Michael's Hospital, Toronto, 1931; Summer Course in School Nursing, 1931) was recently appointed as School Nurse for the King George and George Syme Schools in York Township.

Mrs. Lillian McLean (Owen Sound General and Marine Hospital, Summer Course in School Nursing, 1929) has been appointed to the position of School Nurse in the Lincoln County Health Unit, following the resignation of Miss Maude Wagstaffe (Welland Hospital, St. Catharines).

Miss H. Elizabeth Smith of the staff of the Ontario Department of Health, is taking the four months' course at the Mothercraft Centre, Toronto.

DISTRICT 1

CHATHAM: The annual banquet of the Public General Hospital Alumnae Association was held in the William Pitt Hotel on January 22, 1932, with seventy-three in attendance. Among those present was Mrs. Henry Conn (Sara Resterick, 1895), now of Sarnia, a member of the first graduating class of this hospital. Rev. Dr. Fulton, of First Presbyterian Church, was the speaker of the evening.

At the December meeting of the Alumnae Association, Miss D. Thomas was elected President, Miss Katherine Cracknel, Recording Secretary, and Miss E. Mumery, Treasurer.

WINDSOR: At the recent annual meeting of the Florence Nightingale Association of the Border Cities an appreciable increase in membership was reported. The Association had been most active during 1931 in local professional, social and philanthropic work. Members met weekly to sew for the Women's Relief Committee, while among projects supported were the local V.O.N., the Goodfellows, Christmas cheer for sick members and the Association's room at the Metropolitan Hospital. A cordial invitation is extended to nurses who are newcomers to the Border to attend meetings, which are held the first Tuesday of every month.

DISTRICT 2

KITCHENER: The winter meeting of District No. 2, Registered Nurses Association of Ontario, was held on January 28th at St. Mary's Hospital, Kitchener. The attendance of one hundred and twenty-five showed the ever-increasing interest in the Association. Nurses were present from Fergus, Ayr, Tillsonburg, Woodstock, Galt, Guelph, Preston, Kitchener, Waterloo, Simcoe, Freeport, St. Clements and Brantford. Dr. A. T. Turner, chief of the Medical Staff of St. Mary's Hospital, extended to the nurses a very cordial welcome, and spoke a few words on

the trend of nursing of the present day. The speakers for the afternoon and their topics were as follows: Dr. J. W. Fraser, M.O.H. Kitchener, "Typhoid Fever"; Dr. A. E. Broome, Guelph, "Surgery in Tuberculosis"; and the Rev. Father Mayer, Waterloo, who spoke briefly on the danger of nurses becoming too materialistic and failing to realise their professional responsibility to the mind as well as the body of the patient. These three excellent addresses were greatly appreciated by the audience and a hearty vote of thanks was extended to the speakers by Miss M. Bliss, Guelph. High tea was served by the members of the St. Mary's Alumnae Association, after which the meeting convened for a short session to finish up the routine business.

BRANTFORD: Recent visitors were: Miss Edna Moore, Chief Public Health Nurse, Province of Ontario; Miss Maude Hall, Assistant Superintendent, Victorian Order of Nurses for Canada; and Miss Margaret MacCormack, Superintendent, Stevenson Memorial Hospital, Alliston, Ontario.

The annual meeting of the Florence Nightingale Club was held at the home of Miss Cleator on January 11th. Officers were elected as follows: President, Mrs. J. N. Mitchell; Secretary, Miss T. Dawson; Treasurer, Miss M. McMillan. The February meeting was held at the home of Mr. Diack on February 1st.

The aim of the Brantford Red Cross Home Nursing Committee for the current year is that 150 young women will receive instruction in home nursing. Ably organised by Miss Nellie Yardley, Reg.N., six classes, with a total attendance of 120, are now in progress, the members being drawn from church organisations, office staffs and the Girl Guides. The nurse teachers are: Misses D. Arnold, G. V. Westbrook, F. Batty, T. Dawson, C. Good and H. Kerr. The lectures on communicable diseases, emergencies, and infant care are given by local physicians. The dietetic lectures are given by Miss H. Muri-son, dietitian, Brantford General Hospital.

Sponsored by the local branch of the Victorian Order of Nurses, and under the instruction of Miss H. Kerr, thirty-two little girls are receiving mothercraft lessons.

OWEN SOUND: The regular monthly meeting of the Nurses Alumnae will be held at the home of the Misses Stewart, when plans will be made for the district meeting to be held in Owen Sound in June.

The sympathy of the local nurses is extended to Miss Schultz, assistant superintendent of General and Marine Hospital, on the death of her mother.

GUELPH: Several carloads representing the General Hospital, St. Joseph's Hospital, and the Homewood Sanitarium, attended the meeting of District No. 2, held at St. Mary's Hospital, Kitchener, on January 28, 1932.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Under the joint auspices of the Hamilton Medical Orchestra and the Nurses Alumnae Association of the H.G.H., a very delightful dance and

bridge was held in the ballroom of the Royal Connaught Hotel on the evening of January 27th. The affair was one of the most successful sponsored by the two societies.

The many friends of Miss Shirley Shear-smith (1930) will be glad to know that she is able to return home after her long illness at Mt. Hamilton Sanatorium.

DISTRICT 5

TORONTO: The seventh annual meeting of District 5, R.N.A.O., was held in Osler Hall, Academy of Medicine, Toronto, on January 21st, 1932. Miss Ruby Hamilton, Vice-Chairman, presided in absence of Miss Rahno Beamish owing to illness, and one hundred members were present. No reports were presented by Chairmen of the Nursing Education or Private Duty sections, but Miss Vera Allen of the Public Health section reported having arranged with the Victorian Order of Nurses for Canada to conduct a Maternal Care Institute sponsored by her section to take place in Toronto on February 4th and 5th. The annual reports of Membership, Programme and Permanent Education Fund Committees were presented before the election of officers for 1932, which resulted as follows: President, Miss Rahno Beamish; Vice-President, Miss Dorothy Mickleborough; Secretary-Treasurer, Miss Irene Wiers; Convener Nursing Education, Miss Alberta Bell; Convener, Private Duty Section, Miss Jennie Moore; Convener, Public Health Section, Miss Vera Allen; Councillors, Misses Elizabeth McWilliams, Oshawa; E. J. Johnston, Orillia; Isabel McEwen, M. E. Bullick, Jean Masten and Edith Scott, Toronto.

Dr. Oskar Klotz of the Banting Institute, Toronto, gave a very interesting lecture on the development of pathological laboratory work and described the various departments of the Institute.

The Community Health Association of Greater Toronto held a meeting in the auditorium of the Toronto Humane Society on February 17th. Dr. H. B. Speakman described the work of the Ontario Research Foundation, and Miss Laura Gamble presented a report of her work in connection with the Survey of Convalescent Care.

The many Toronto friends of Miss Edna Moore are delighted to welcome her on her return from New York, where she was attached to the N.P.O.H.N., to take over her new work as Chief Nurse with the Provincial Department of Health.

The Maternal Care Institute arranged by the Public Health Section of District 5, R.N.A.O., and conducted by Miss Ethel Cryderman, Ontario Supervisor of the Victorian Order of Nurses for Canada, was held in the class room of the Toronto General Hospital on February 4th and 5th. The attractive rooms on the fifth floor of the West Residence were, for the third time, placed at the disposal of the nurses attending the Institute, in the usual hospitable style of the T.G.H. Twenty-two nurses were registered for the Institute and forty-five attended the evening lecture on "Nutrition in Preg-

nancy," given by Miss Marjorie Bell, nutritionist, with the Montreal Branch of the Victorian Order. Dr. W. B. Hendry, Professor of Obstetrics, University of Toronto, who was present at the closing session to take part in discussion and answer questions, contributed a good deal of valuable information and advice as a conclusion to a very successful Institute. Miss Marion Morrison expressed thanks to Miss Cryderman for the energy and enthusiasm which characterised her conduction of the sessions.

OSHAWA: At the annual meeting of the Alumnae held at the Nurses' Residence, Oshawa General Hospital, January 4, 1932, the following officers were elected: Honorary President, Miss E. McWilliams; President, Mrs. M. Yelland; Vice-President, Miss J. McIntosh; Second Vice-President, Mrs. D. Redpath; Secretary, Miss H. Batty; Treasurer, Miss J. Cole; Corresponding Secretary, Miss H. Hutchinson; Assistant Corresponding Secretary, Mrs. W. Luke; Visiting Convener, Mrs. M. Canning; Social Convener, Miss I. Cook; Membership Convener, Miss J. Cole; Private Duty Convener, Miss M. Quinn; Programme Convener, Miss L. Hinton; Hospital Auxiliary Representatives, Mrs. M. Canning, Mrs. B. A. Brown, Mrs. Hare. Miss A. Scott was in charge of the meeting. Mrs. M. Yelland gave a report of the activities of the past year, and the treasurer, Miss J. Cole, in her financial statement showed that the Alumnae had a good balance on hand.

WOMAN'S COLLEGE HOSPITAL, TORONTO: The January meeting of the Alumnae will always hold fond memories for the members present, as they again saw the "School's everlasting torch" taken up, to be carried far into Central Brazil by Miss Jennings of the Association. The members wished her bon voyage, and presented her with a travelling rug. Miss Fleming, of St. George Street School, addressed the meeting on the subject of "Training Children from the Age of Two to Five Years," and answered any questions raised by the members.

In February, Mrs. Irving Robertson spoke on the "Art of Mothercraft in the Community".

Miss Bankirby, 1923, has established on Avenue Road, an attractive foodshop called the Butler's Pantry, and which is artistically decorated in black and white.

Recently, Miss Eleanor Clarke entertained at a very pleasant tea in honour of Miss Bolton, 1924, who is serving in the Pine River District under the M.G.C.C. Among those present were Mrs. Raymor, Misses Henry, Hawkes, Roberts, Allan and Collier.

The Alumnae extend their sincerest sympathy to Miss Meiklejohn on the loss of her revered mother.

DISTRICT 6

PORT HOPE: Port Hope has two very active Men's Clubs, The Rotary and The Lions. Both clubs are doing excellent work for their fellow citizens. Crippled children are helped by expert orthopedic advice and surgery.

Children's throats receive attention. Where parents cannot meet the expense themselves, the Rotarians have helped. Local dentists have inspected the teeth of all the children at the schools. The Lions Club made arrangements with the Department of Health, who sent Dr. McKenzie Smith and Miss Lefler, a nurse, to inspect all school children's eyes, also free of charge to the parents. The Town Parks have been greatly improved, and the acreage increased by the Rotarians. The Port Hope Hospital is open every two weeks to Dr. Montgomery, who has care of the Mental Health of the citizens of the town and surrounding country. Dr. Montgomery and Miss Aikenhead and their staff will see anyone who wishes to consult them, if they make an appointment with the superintendent of the Hospital.

LINDSAY: At a meeting of Chapter 3, District 6, held at the Ross Memorial Hospital, Lindsay, on January 26th, there was a good attendance. After a concise talk on the aims and work of the Association given by the President, six of the nurses applied for membership forms. One of the pleasing features of the afternoon's programme was a talk from Dr. White of Lindsay on his trip to Alaska.

DISTRICT 8

OTTAWA: About two hundred members of District 8, R.N.A.O., held an interesting all-day meeting in the Chateau Laurier on January 28th. Reports were presented, addresses of interest given and officers elected for the year. Miss Alice Ahern presided. The morning meeting was devoted to 'business relative to the Association and the presentation of reports covering the various activities of the groups. In the afternoon Dr. W. J. Stevens, Ottawa, gave a very interesting paper, illustrated by lantern slides, on "Obstetrics and Rectal Anaesthesia," and Dr. Norman Guiou, Ottawa, an illustrated lecture on "Operative Procedure in Obstetrics". A splendid demonstration was given by Miss K. McIlwraith and Miss Helen Stewart of the Ottawa branch of the Victorian Order of Nurses on "Preparations for Confinement in a Home". Miss Dorothy Percy was elected Chairman, Miss Blanche Anderson Vice-Chairman, and Miss A. G. Tanner was re-elected Secretary-Treasurer. Councilors elected are: Misses E. C. McIlwraith, Jean Church, Mary Slinn, Ruth Pridmore, Ella Rochon, and Amy Brady.

QUEBEC

WESTERN HOSPITAL, MONTREAL: The annual meeting of the Alumnae was held in the Nurses' Home, January 11th, at which the officers were elected for 1932. After considerable business was taken up, refreshments were served in the Lounge. In December the Alumnae took charge of a family of seven, providing clothing, Christmas dinner and cheer, which seemed to be greatly appreciated by them.

WOMEN'S GENERAL HOSPITAL, MONTREAL: The annual meeting of the Alumnae Association was held on January 20, 1932. Reports of the President and Treasurer were read, and Miss George, Honorary President, gave a short address. The members extend their deepest sympathy to Miss Grace Wilson in her recent bereavement, on the death of her sister.

SHERBROOKE: An unusually interesting and largely attended meeting of the Eastern Townships Graduate Nurses Association was held at the McKinnon Memorial Building, on February 4th, when about twenty-five nurses gathered for their annual business session. A turkey dinner was served at 8 p.m. The table decorations were most artistic and unusual. The Association's colours, blue and yellow, with several dolls dressed as nurses and candles in silver holders were used. The President, Miss Stevens, presided. After dinner, business was transacted, reports read and officers elected.

SASKATCHEWAN

The annual meeting of the Saskatchewan Registered Nurses Association is to be held in Saskatoon, March 31 and April 1, 1932. A study of the Report on the Survey of Nursing Education in Canada will occupy the attention of the delegates.

REGINA: A meeting of the Grey Nuns' Hospital Alumnae Association was held on February 11 at the home of Miss Rotner. The following officers were elected for 1932: Hon. President, Sister O'Grady; President, Mrs. Oberhaffner; First Vice-President, Miss McGrath; Second Vice-President, Miss Rotner; Secretary-Treasurer, Miss V. Harrop, 2164 Angus St., Regina; Executive, Mrs. Tanney, Mrs. Fyfe, Misses Gropp and McQuatt; Visiting Committee, Mrs. McKeevor, Misses Mueller and Patterson; Membership Committee, Miss McQuatt, Mrs. Gall, Miss Olive Keys; "The Canadian Nurse" Representative, Mrs. A. Tanney, Department of Public Health, Regina; Local Council of Women, Mrs. Oberhaffner. Mrs. A. Tanney (1922), of Department of Public Health, addressed the meeting on Public Health Nursing and referred to a new post-graduate course, namely, "Aviation in Nursing". She also recommended each nurse to subscribe to "The Canadian Nurse". Arrangements were partly completed for entertainment for the 1932 Graduating Class. Five dollars was donated to the Salvation Army Tea and \$3.00 for affiliation to the Local Council of Women. Miss Sawyer (1929) is taking a post-graduate course at the Sanatorium, Prince Albert. Miss Irons (1929), former president of the Alumnae, left recently for the East, where she entered the Sisterhood of St. John the Divine of the Anglican Church. Miss Jansen (1929) of Morse, returned from the Royal Victoria Hospital, Montreal, after completing a course in Obstetrics.

C.A.M.N.S.

SASKATOON: On January 23, 1932, there passed away in Victoria, B.C., one of Saskatoon's best known and greatly esteemed citizens, Mrs. J. D. Macdonald, formerly Nursing Sister Harriet Graham, of New Glasgow, N.S., and graduate of St. Luke's Hospital, New York City. Volunteering for overseas service in August, 1914, she accompanied the first Canadian contingent to France, where at No. 1 Casualty Clearing Station she served as Matron for the greater part of the war. Later, in recognition of her splendid services, she was decorated by His Majesty King George with the Royal Red Cross, first rank.

Returning to Canada in 1919, Nursing Sister Graham served for two years as Matron of the Military Hospital at Burlington, Ontario.

Since her marriage her home had been in Saskatoon, where she took a prominent part in women's work and interests, having served as a member of the City Hospital Board and as President of the local branch, Victorian Order of Nurses. Endowed with exceptional executive and administrative ability and forceful but most winning personality, Mrs. Macdonald endeared herself to all those with whom she came in contact, making many friends in Saskatoon as she had done in home

and professional life of earlier days. The sympathy of her many friends is extended to her husband, her two sisters and brother.

TORONTO: The officers and executive of the Overseas Nurses Club of Toronto entertained at tea at the home of the President, Mrs. Jack Bell, on February 6th. Miss Edith Campbell, A.R.R.C., Hon. President, received with Mrs. Bell, and over two hundred members filled the rooms, renewing old friendships and talking over old times. Among the past presidents pouring tea at the attractive table, with its centre of spring flowers, were Mrs. Arthur Scott and Mrs. R. Robertson (Pauline Ivy). Matron Hartley, A.R.R.C., was unable to be present owing to the serious illness of Miss Catherine Graham, who passed away later on in the day at Christie Street Hospital. Miss Graham went overseas in August, 1917, where she was attached to McGill Unit and served in France and England until her return to Canada in August, 1919. After some time spent at the officers' hospital on Spadina Ave., and at the Brant Hospital, Burlington, she was attached to the staff at Christie Street Hospital, where she was held in high esteem by patients and staff. Miss Graham served on the Executive of the Overseas Club of Toronto, and her interest and support will be missed by many of its members.

BIRTHS, MARRIAGES AND DEATHS**BIRTHS**

BRYANT—On October 30, 1931, at Sherbrooke, P.Q., to Mr. and Mrs. Clifford Bryant (Isobel MacCauley, Sherbrooke Hospital, 1923), a daughter, Jacquelin Ann.

CLARKE—On February 3, 1932, at Chatham, Ont., to Mr. and Mrs. Fred Clarke (Eleanor Sherratt, Public General Hospital, Chatham, 1917), a son, Charles Fredrick.

COLLINS—On February 8, 1932, at St. Boniface, Man., to Mr. and Mrs. H. Collins (T. Shelton, St. Boniface Hospital, 1924), a son.

COLQUETTE—On January 4, 1932, to Mr. and Mrs. Bruce Colquette (Ina M. Burnett, Toronto Western Hospital, 1929), a son.

COON—On January 11, 1932, at Norfolk, Virginia, U.S.A., to Dr. and Mrs. Willard Coon (Lulu M. Docherty, Toronto Western Hospital, 1922), a daughter.

FLOCK—On January 2, 1932, at Chatham, Ont., to Mr. and Mrs. Earl Flock (Mildred Riseborough, Public General Hospital, Chatham, 1930), a son, Earl Douglas.

FOURNIER—On January 18, 1932, at St. Boniface, Man., to Mr. and Mrs. Fournier (Alma Gauthier, St. Boniface Hospital, 1923), a son.

FRIESEN—In Regina, to Mr. and Mrs. Ed. Friesen (Cecelia Fahlman, Grey Nuns' Hospital, Regina, 1930), a son.

GILLESBY—On January 16, 1932, at Owen Sound, Ont., to Mr. and Mrs. James Gillesby (Grace Rusk, Owen Sound General and Marine Hospital, 1923), a daughter.

HARDING—On December 26, 1931, at Montreal, to Mr. and Mrs. Hugh Harding (Muriel McCollum, Montreal General Hospital, 1923), a daughter, Mary Lou.

JONES—On December 11, 1931, at Montreal, to Mr. and Mrs. L. E. P. Jones (Jean Crate, Ottawa Civic Hospital, 1927), a son.

KINNEY—On November 14, 1931, at Cleveland, Ohio, to Mr. and Mrs. Leroy Kinney (Myrtle Last, Kitchener and Waterloo Hospital, 1923), a son.

McARTER—Recently, at Scotsguard, Sask., to Mr. and Mrs. McArter (Marian Weeks, Grey Nuns' Hospital, Regina, 1922), twins.

O'SULLIVAN—On January 14, 1932, at St. Boniface, Man., to Mr. and Mrs. J. O'Sullivan (Gladys Walch, St. Boniface Hospital, 1928), a son.

SMITH—On December 31, 1931, at Chatham, Ont., to Mr. and Mrs. Murray Smith (Harriet Furness, Wellesley Hospital, Toronto, 1921), a daughter, Helen Christine.

URE—In November, 1931, to Mr. and Mrs. Ure (Corinne Glenny, Hamilton General Hospital, 1926), a daughter.

ZOPPI—On January 10, 1932, at Ottawa, to Mr. and Mrs. Fred R. Zoppi (Evelyn A. Pink, Ottawa Civic Hospital, 1923), a daughter.

MARRIAGES

BAITZ—WILSON—On December 31, 1931, at Ottawa, Audrey Chalmers Wilson (Ottawa Civic Hospital, 1927) to Charles C. G. Baitz, of Union City, N.J.

CASELL—DUCKWITH—On January 30, 1932, at Oshawa, Emily Edythe Duckwith (Oshawa General Hospital, 1926) to Conyn Robert Cassell, of San Diego, California.

DREW—MILLER—On December 29, 1931, at Port Parry, Ont., Retta Gertrude Miller (Oshawa General Hospital, 1930) to E. Willis Drew, of Oshawa.

ERB—MEYSCHIN—On September 28, 1931, at Stratford, Ont., Selma Meyschein (Stratford General Hospital, 1927) to Irvin E. Erb, of Kitchener, Ont.

GILLAN—BOURKE—On January 28, 1932, at Pakenham, Mary Bourke (Ottawa Civic Hospital, 1931) to Matthew W. Gillan.

GOLDSMITH—SEGUIN—On September 25, 1931, in Montreal, Minnie A. Seguin (Woman's General Hospital) to L. Goldsmith, Sr.

KERR—KEUNEMAN—On January 30, 1932, Irene Keuneman (St. Boniface, 1924) to Mr. Melvin H. Kerr, of Winnipeg.

MALONE—DENNIS—On December 23, 1931, Winifred Dennis (Hamilton General Hospital, 1931), to A. F. Malone, Principal of the Continuation School, Port Burwell, Ont.

PETITE—STAPLES—On January 5, 1932, at Montreal, Myrtle Staples (Montreal General Hospital, 1929) to James Petite.

WILSON—MCNICHOL—On November 4, 1931, at Owen Sound, Ont., Mildred McNichol (Owen Sound General and Marine Hospital, 1923) to Robert John Wilson, of Anten Mills, Ont.

GRADUATE NURSES ASSOCIATION OF BRITISH COLUMBIA (Incorporated 1918)

An examination for title and certificate of Registered Nurse of British Columbia will be held April 13th, 14th and 15th, 1932.

Names of candidates for this examination must be in the office of the Registrar not later than March 14th, 1932.

Full particulars may be obtained from—

HELEN RANDAL, R.N., Registrar,
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DEATHS

DOWN—On January 9, 1932, at Tisdale, Sask., Elda Laurel Down (St. Boniface Hospital, St. Boniface, Man., 1923).

GRAHAM—On February 6, 1932, at Christie Street Hospital, Catherine Graham, formerly attached to the McGill Unit, Canadian Army Medical Corps, and later at Brant Hospital, Burlington, and Christie Street Hospital, Toronto.

KRUGER—On January 26, 1932, at Toronto, Margaret E. Code (Toronto Western Hospital, 1927), wife of Dr. W. Cecil Kruger.

LANGDALE—On February 11, 1932, at Manitoba Sanitarium, Ninette, Mrs. F. E. Langdale (Maude Moulton, Sherbrooke Hospital, Sherbrooke, Que., 1900), member of the nursing staff, Winnipeg School Board, Winnipeg, Man.

MOLLISON—Suddenly, in Toronto, Miss A. J. Mollison, Hamilton General Hospital, 1927.

MACDONALD—On January 28, 1932 at Victoria, B.C., Mrs. J. D. Macdonald, formerly Nursing Sister Harriet Graham, of New Glasgow, and graduate of St. Luke's Hospital, New York City.

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Examinations for Qualifications as Registered Nurse in the Province of Quebec will be held in Montreal and elsewhere on April 25th, 26th, 27th, 1932.

Those wishing to write must apply for forms, etc., to the Registrar, and all applications must be in the office of the Association before April 1st. No application can be considered after that date.

E. FRANCES UPTON, R.N.,
Executive Secretary and Registrar,
Room 221,
1396 St. Catherine Street West,
Montreal, P.Q.

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

are to take place 18th and 19th May, 1932. Requests for application forms should be made at once and form returned before April 18, 1932, together with registration fee of \$10.00, and, if graduated, diploma of school. No undergraduates may write unless they have passed successfully all final Training School examinations and are within six weeks of completion of period of training of their school.

L. F. FRASER, Registrar,
10 Eastern Trust Building,
Halifax, N.S.

Official Directory

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GRADUATE NURSES' ASSOCIATION OF BRITISH COLUMBIA

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REGISTERED NURSES' ASSOCIATION OF ONTARIO (Incorporated 1925)

President, Miss Mary Millman, 126 Pape Ave., Toronto; First Vice-President, Miss Marjorie Buck, Norfolk General Hospital, Simcoe; Second Vice-President, Miss Priscilla Campbell, Public General Hospital, Chatham; Secretary-Treasurer, Miss Matilda Fitzgerald, 380 Jane Street, Toronto.

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ASSOCIATION OF REGISTERED NURSES OF THE PROVINCE OF QUEBEC (Incorporated 1920)

Advisory Board, Misses Mary Samuel, L. C. Phillips, M. F. Hersey, Bertha Harmer, M.A., Mabel Clint, Rev. Mere M. V. Allaire, Rev. Soeur Augustine; President, Miss Mabel K. Holt, Montreal General Hospital; Vice-Presidents (English) Miss C. V. Barrett, Royal Victoria Montreal Maternity Hospital, (French) Mlle. Edna Lynch, Nursing Supervisor Metropolitan Life Assurance Co.; Hon. Secretary, Miss Elsie Alder, Royal Victoria Hospital; Hon. Treasurer, Miss Olga V. Lilly, Royal Victoria Montreal Maternity Hospital; Other members, Miss Flora Aileen George, The Woman's General Hospital, Miss Marion Nash, V.O.N., Montreal, Madame Caroline Vachon, Hotel Dieu, Montreal; Miss Sara Matheson, Miss Charlotte Nixon; Conveners of Sections, Private Duty (English), Miss Sara Matheson, Apt. 24, Haddon Hall Apts., 2151 Lincoln Ave., Montreal; (French) Mlle. Alice Lepine, Hopital Notre Dame; Nursing Education (English), Miss Flora Aileen George, Woman's General Hospital, Westmount; (French), Rev. Soeur Augustine, Hopital St. Jean-de-Dieu, Gamelin, P.Q.; Public Health, Miss Marion Nash, V.O.N., 1246 Bishop St.; Board of Examiners, Miss C. V. Barrett (Convener), Royal Victoria Montreal Maternity Hospital, Miss R. D. Bourque, Universite de Montreal (Ecole d'Hygiene Appliquee), Mlles. Edna Lynch, Hopital Notre Dame, Laure Senechal, Hopital Notre Dame, Misses Rita Sutcliffe, Alexandra Hospital, Marion Lindeburgh, School for Graduate Nurses, McGill University, Olga V. Lilly, Royal Victoria Montreal Maternity Hospital; Executive Secretary, Registrar and Official School Visitor, Miss E. Frances Upton, Suite 221, 1396 St. Catherine St., W. Montreal.

SASKATCHEWAN REGISTERED NURSES' ASSOCIATION. (Incorporated March, 1927)

President, Miss Elizabeth Smith, Normal School, Moose Jaw; First Vice-President, Miss M. H. McGill, Normal School, Saskatoon; Second Vice-President, Miss G. M. Watson, City Hospital, Saskatoon; Councillors, Miss R. M. Simpson, Department of Public Health, Regina, Sister Mary Raphael, Providence Hospital, Moose Jaw; Conveners of Standing Committees, Public Health, Mrs. E. M. Feeny, Dept. of Public Health, Regina; Private Duty, Miss L. B. Wilson, 2012 Athol St., Regina; Nursing Education, Miss G. M. Watson, City Hospital, Saskatoon; Secretary-Treasurer and Registrar, Miss E. E. Graham, Regina College, Regina.

CALGARY ASSOCIATION OF GRADUATE NURSES

Hon. President, Mrs. Stuart Brown; Acting President, Miss K. Lynn; Second Vice-President, Miss Barber; Treasurer, Miss M. Watt; Recording Secretary, Mrs. B. J. Charles; Corresponding Secretary, Miss I. Jackson; Registrar, Miss D. Mott, 616 15th Ave. W.; Convener Private Duty Section, Mrs. R. Hayden.

EDMONTON ASSOCIATION OF GRADUATE NURSES

President, Mrs. K. Manson; First Vice-President, Miss B. Emerson; Second Vice-President, Miss F. Welsh; Secretary, Miss C. Davidson; Corresponding Secretary, Miss J. G. Clow, 11138 82nd Ave.; Treasurer, Miss L. Ward, 11328 102nd Ave.; Programme Committee, Miss A. L. Young, Miss I. Johnson; Sick Visiting Committee, Miss P. Chapman, Miss Gavin. Representative to "The Canadian Nurse," Miss M. Griffith, 10806 98th St.

MEDICINE HAT GRADUATE NURSES ASSOCIATION

President, Mrs. Mary Tobin; First Vice-President, Mrs. C. Anderson; Second Vice-President, Miss L. Green; Secretary, Miss M. E. Hagerman, City Court House, 1st Street; Treasurer, Miss Edna Auger; Convener of New Membership Committee, Mrs. C. Wright; Convener of Flower Committee, Miss M. Murray; Correspondent, "The Canadian Nurse," Miss F. Smith.

Regular meeting First Tuesday in month.

A.A., ROYAL ALEXANDRA HOSPITAL, EDMONTON, ALTA.

Hon. President, Miss F. Munroe; President, Mrs. Scott Hamilton; First Vice-President, Miss V. Chapman; Second Vice-President; Mrs. C. Chinneck; Recording Secretary, Miss G. Allyn; Corresponding Secretary, Miss A. Oliver, Royal Alexandra Hospital; Treasurer, Miss E. English, Suite 2, 10014 112 Street.

NELSON GRADUATE NURSES ASSOCIATION

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VANCOUVER GRADUATE NURSES ASSOCIATION

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A.A., ST. PAUL'S HOSPITAL, VANCOUVER

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A.A., VANCOUVER GENERAL HOSPITAL

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A.A., ST. BONIFACE HOSPITAL, ST. BONIFACE, MAN.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

A.A., WINNIPEG GENERAL HOSPITAL

Hon. President, Mrs. W. A. Moody, 97 Ash St.; President, Mrs. J. A. Davidson, 39 Westgate; First Vice-President, Mrs. S. Harry, Winnipeg General Hospital; Second Vice-President, Miss I. McDiarmid, 303 Langside St.; Third Vice-President, Miss E. Gordon, Research Lab., Medical College; Recording Secretary, Miss C. Briggs, 70 Kingsway; Corresponding Secretary, Miss M. Duncan, Winnipeg General Hospital; Treasurer, Mrs. H. I. Graham, 99 Euclid St.; Sick Visiting, Miss W. Stevenson, 535 Camden Place; Programme, Miss C. Lethbridge, 877 Grosvenor Ave.; Membership, Miss A. Pearson, Winnipeg General Hospital.

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Chairman, Miss Alice Ahern; Vice-Chairman, Miss D. M. Percy; Secretary-Treasurer, Miss A. G. Tanner, Ottawa Civic Hospital; Councillors, Misses M. Stewart, M. Slinn, G. Woods, M. B. Anderson, Amy Brady, Ella Rochon; Conveners of Committees, Membership, Miss E. Rochon; Publications, Miss M. Stewart; Nursing Education, Miss M. E. Anderson; Private Duty, Miss Mary Slinn; Public Health, Miss Marjorie Robertson; Representative to Board of Directors, Miss A. Ahern.

DISTRICT No. 10, REGISTERED NURSES ASSOCIATION OF ONTARIO

Chairman, Miss A. Boucher; First-Vice President, Mrs. F. Edwards; Second Vice-President, Miss V. Lovelace; Secretary-Treasurer, Miss M. Racey; Conveners of Committees: Nursing Education, Miss B. Bell; Public Health, Miss L. Young; Private Duty, Miss I. Sheehan; Publication, Miss M. Flannagan; Membership, Miss M. Siden, Miss D. Elliott; Social, Miss E. Hamilton, Miss Chiver-Wilson, Miss E. McTavish; Representatives to Board of Directors Meeting, R.N.A.O., Mrs. F. Edwards.

Meetings held first Thursday every month.

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A.A., BELLEVILLE GENERAL HOSPITAL

Hon. President, Miss Florence McIndoo; President, Miss E. McEwen; Vice-President, Miss E. Cryderman; Secretary, Miss B. Cryderman; Treasurer, Miss E. Wright; Flower Committee, Miss J. Thompson and Miss M. MacFarlane; Representative, "The Canadian Nurse," Mrs. J. Campbell.

Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charnley; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

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A.A., HAMILTON GENERAL HOSPITAL

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Hon. President, Mother Martina; President, Miss E. Quinn; Vice-President, Miss H. Fagan; Treasurer, Miss I. Loyst, 71 Bay Street S.; Secretary, Miss M. Maloney, 31 Erie Avenue; Convener, Executive Committee, Miss M. Kelley; "The Canadian Nurse," Miss Moran.

A.A., HOTEL DIEU, KINGSTON, ONT.

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A.A., KINGSTON GENERAL HOSPITAL

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A.A., KITCHENER AND WATERLOO GENERAL HOSPITAL

Hon. President, Miss K. W. Scott; President, Miss L. McTague; First Vice-President, Mrs. V. Snider; Second Vice-President, Mrs. R. Petch; Secretary, Miss T. Sittler, 32 Troy St.; Asst. Secretary, Miss J. Sinclair; Treasurer, Miss E. Ferry; "The Canadian Nurse," Miss E. Hartlieb.

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Hon. President, Mother M. Pascal; Hon. Vice-President, Sister St. Elizabeth; President, Miss Madeline Baker; First Vice-President, Miss Olive O'Neill; Second Vice-President, Miss Florence Connolly; Recording Secretary, Miss Stella Gignac; Corresponding Secretary, Miss Gladys Gray; Treasurer, Miss Alice McTague; Press Representative, Miss Lillian Morrison; Representatives to Registry Board, Misses Elizabeth Armishaw, Rhea Ronatt.

A.A., VICTORIA HOSPITAL, LONDON, ONT.

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A.A., NIAGARA FALLS GENERAL HOSPITAL

Hon. President, Miss M. S. Park; President, Mrs. J. Taylor; Vice-President, Miss L. McConnell; Secretary, Miss J. McClure; Treasurer, Miss I. Hammond, 632 Ryerson Crescent, Niagara Falls; Convener Sick Committee, Miss A. Irving; Asst. Convener Sick Committee, Miss Coutts; Convener Private Duty Committee, Miss K. Prest.

A.A., ORILLIA SOLDIER'S MEMORIAL HOSPITAL

Hon. President, Miss E. Johnston; President, Miss G. Went; First Vice-President, Miss McMurray; Second Vice-President, Miss S. Dudenhofer, Secretary-Treasurer, Miss M. B. MacLelland, 128 Nississaga St. W.

Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

Hon. President, Miss MacWilliams; President, Miss Ann Scott, 26 King Street E., Oshawa; Vice-President, Miss Emily Duckwith; Second Vice-President, Mrs. H. Harland; Secretary, Mrs. Mabel Yelland, 14 Victoria Apts., Simcoe St. S., Oshawa; Asst. Secretary, Miss Jessie McIntosh; Corresponding Secretary, Miss Helen Hutchison, 14 Victoria Apts., Simcoe St. S., Oshawa; Treasurer, Miss Jane Cole; Social Convener, Miss Amber Sonley, Visiting and Flower Convener, Mrs. M. Canning; Convener Private Duty Nurses, Miss Margaret Dickie; Representative, Hospital Auxiliary, Mrs. M. Canning, Mrs. E. Hare, Mrs. B. A. Brown.

A.A., ST. LUKE'S HOSPITAL, OTTAWA

Hon. President, Miss Maxwell; President, Miss Doris Thompson; Vice-President, Miss Diana Brown; Secretary, Miss Isobel Allan, 408 Slater Street, Ottawa; Treasurer, Mrs. Florence Ellis; Nominating Committee, Misses Mina MacLaren, Hazel Lytle, Katherine Tabbie.

**A.A., LADY STANLEY INSTITUTE, OTTAWA
(Incorporated 1918)**

Hon. President, Miss M. A. Catton, 2 Regent St.; Hon. Vice-President, Miss Florence Potts; President, Mrs. W. Elmitt; Vice-President, Miss M. McNiece, Perley Home, Aylmer Ave.; Secretary, Mrs. Lou Morton, 49 Bower Ave.; Treasurer, Miss Mary C. Slinn, 204 Stanley Ave.; Board of Directors, Miss E. McColl, Vimy Apts., Charlotte St., Miss C. Flack, 152 First Ave.; Miss L. Belford, Perley Home, Aylmer Ave.; Miss E. McGibbon, 114 Carling Ave.; Representative "The Canadian Nurse," Miss A. Ebbs, 80 Hamilton Ave.; Representative to Central Registry, Miss A. Ebbs, 80 Hamilton Ave.; Miss Mary C. Slinn, 204 Stanley Ave.; Press Representative, Miss E. Allen.

A.A., OTTAWA CIVIC HOSPITAL

Hon. President, Miss Gertrude Bennett; President, Miss Evelyn Pepper; First Vice-President, Miss Elizabeth Graydon; Second Vice-President, Miss Dorothy Moxley; Treasurer, Miss Winnifred Gemmell, 221 Gilmour St.; Recording Secretary, Miss Greta Wilson, 489 Metcalfe St.; Corresponding Secretary, Miss Eileen Graham, 41 Willard St.; Councillors, Mrs. G. W. Dunning, Misses Elizabeth Curry, Gertrude Moloney, Mary Lamb, Gladys Moorehead; Convener of Flower and Sick Visiting Committee, Miss Margaret McCallum; Press Correspondent, Miss E. Osborne.

A.A., OTTAWA GENERAL HOSPITAL

Hon. President, Rev. Sr. Flavie Domitille; President, Miss K. Bayley; First Vice-President, Mrs. McEvoy; Second Vice-President, Miss M. Munroe; Secretary-Treasurer, Miss G. Clarke; Membership Secretary, Miss M. Daley; Representatives to Local Council of Women, Mrs. C. L. Devitt, Mrs. A. Latimer, Mrs. E. Viau, Miss F. Nevins; Representatives to Central Registry, Miss L. Egan, Miss A. Stackpole; Representative to "The Canadian Nurse," Miss Dorothy Knox.

A.A., OWEN SOUND GENERAL AND MARINE HOSPITAL

Hon. President, Miss B. Hall; President, Mrs. D. J. McMillan, 1151 3rd Ave. W.; Vice-President, Miss C. Thompson; Secretary-Treasurer, Miss A. Mitchell, 466 17th St. W.; Assistant Secretary-Treasurer, Mrs. Tomlinson; Flower Committee, Miss M. Story, Miss C. Stewart, Mrs. Frost; Programme Committee, Misses Sim, C. Stewart; Press Representative, Miss M. Morrison.

A.A., NICHOLLS HOSPITAL, PETERBORO, ONT.

Hon. President, Mrs. E. M. Leeson; President, Miss H. M. Anderson; First Vice-President, Miss L. Simpson; Second Vice-President, Miss M. Watson; Treasurer, Miss L. Ball; Secretary, Miss I. Armstrong; Corresponding Secretary, Miss H. Hooper, Peterboro Hospital; Convener Social Committee, Miss A. Dobbin; Convener of Flower Committee, Miss S. Armstrong.

A.A., SARNIA GENERAL HOSPITAL

Hon. President, Miss M. Lee; President, Miss L. Seigrist; Vice-President, Miss B. McFarlan; Secretary, Miss A. Silverthorne; Treasurer, Miss M. Woods; "The Canadian Nurse," Miss E. Dickey; Flower Committee (Convener), Miss J. McKenzie; Programme and Social Committee, Misses P. Humphrey, O. Banting, B. McFarlan; By-laws Committee, Misses O. Banting, M. McCrae, E. Dickey.

A.A., STRATFORD GENERAL HOSPITAL

Hon. President, Miss A. M. Munn; President, Miss Florence Kudoba; Vice-President, Miss Rena Johnston; Secretary-Treasurer, Miss Alma Rock, 97 John St.; Convener of Committees: Social, Mrs. Lloyd Miller; Flower, Miss Margaret Derby; Correspondent, "The Canadian Nurse," Miss Helen Dinsdale.

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Modern Methods and Treatment of Cancer

By JOHN W. S. McCULLOUGH, M.D., D.P.H.

Your Association has done me the great honour of asking me to speak to you on the subject of Cancer.

Until the Royal Commission appointed by the Government last spring has made its Report, I cannot speak of the actual work of the Commission, which I accompanied on its investigation of the subject in the United States and Europe, but I may say that there is no better clinical work being done anywhere the Commission visited than is carried on right here in Toronto; the only difference is that, while we have had until recently but half a gram of radium and one deep x-ray machine, clinics for the treatment of cancer in Europe have many of them, eight grams of radium and six to eight high voltage x-ray apparatus.

Increase of Cancer

There seems to be little doubt that cancer is on the increase, but not to the extent to which statistics point. There are a few reasons why the total increase is apparent. There are:

- (1) the better records of today;
- (2) the greater skill in diagnosis;
- (3) the increase in the number of people of the cancer age;
- (4) the better education of the public in preventive medicine of all kinds, which enables the layman and woman to appreciate the earlier signs of the disease.

With a continuance of, and a wide increase in public health education, particularly among the children of today, the future men and women will detect the early signs of cancer more readily and offer themselves to the doctor for earlier diagnosis and treatment.

With reference to the health education of children, one cannot expect *all* of them to be so apt as the one Dr. Joseph Colt Bloodgood tells of. He was delivering a lecture on health and, wishing to make the point that parents were not aware how much their children were taught in the primary schools about the rules of health and preventive medicine, he selected a little girl about ten years old, sitting in the front seat beside the mayor, and asked her to stand up and tell the audience what she would do if she stepped on a rusty nail. She at once answered that she would wash her foot in soap and warm water, bathe the wound with alcohol, then go to the doctor and ask him to give her a dose of tetanus antitoxin. Now if Kipling were telling this story, he would tell it as a lie. There was tremendous applause, and Bloodgood was immensely gratified at the result of his experiment. Speaking to the mayor about the matter at a dinner next day, the latter said that the only comment among the audience was that it was a "put-up job".

Speaking at Chicago recently, Dr. Bloodgood said: "A beautiful woman doesn't have cancer of the face. Why? Because with the first blemish on her face she goes to a physician. That is a valuable lesson for men to learn.

"Women smoke, but they do not develop cancer of the mouth. The reason—they keep their teeth free of nicotine. That's another lesson for their husbands and brothers."

But there is after all this, a real increase in the incidence of cancer. If we take our own country alone, the mortality from cancer has shown a successive and steady rise over a long

period, one must admit that cancer is increasing.

Statistics of Cancer Mortality

I suppose you are not fond of statistics, and I shall burden you with only sufficient to convince you that there is an alarming increase of this affection. Beginning with 1914 the mortality rate for cancer in Ontario was 69 per 100,000 of population; in 1929 the rate was 104, and last year 109.5, an increase of $5\frac{1}{2}$ per 100,000 in a single year.

During the last decade the rate of increase has been nearly 20.0 per 100,000 of population, or a relative increase of 31%. For certain regions of the body, the stomach, the intestines, and the female organs of generation, the increase has been particularly marked and is in comparative accord with that found in most countries. The annual loss of life from cancer in Ontario has, in the aggregate, now reached 3,631 and the total number of cases cannot fall short of 10,000.

The increase in cancer mortality is general all over Canada, the rate in 1930 being 93, or an increase of 5 over that of 1929, and of 470 in the number of deaths.

The newer sections of the country, Alberta, Manitoba and Saskatchewan, with fewer people of the cancer age, have the lower rates.

The records for England and Wales since 1847, show an ever-increasing tide of cancer mortality. During this period the rate has risen from 27.4 per 100,000 to 145.3 (1930). The United States, and particularly the continent of Europe, show an equal or greater increase, and all over the civilised world there is the highest interest in research as to the cause of cancer, and experiments in treatment designed to control this mighty scourge.

The Nature of Cancer

The human body is composed of millions of cells, cells that can be seen only when magnified about 500 times, when they appear to be of the size of a small pin's head.

In its simplest form the cell is a spherical body with a definite wall,

and semi-solid contents in the middle of which is a smaller spherical body known as the nucleus, and upon which the life of the whole cell depends. In its normal life history the nucleus and subsequently the cell itself divides. The cells grow to full size and are ready to divide in their turn. The process of further division depends upon a number of circumstances, many of which are unknown, but in part it depends on the nature of the cell. Thus the skin is constantly being renewed by division of the deepest layer of cells, whereas nerve cells are never renewed once they have been formed. Although cells typically are of spherical form, they may, from pressure, become flattened, columnar, polyhedral or irregular in shape.

The cancer cell is a normal cell of the body, but for some unknown reason this cell departs from the ordinary habit, and not only divides but continues to subdivide indefinitely. Under the microscope one can observe the birth and growth of the cancer cell, can see it spread, invade and destroy the healthy tissues: one can distinguish cancer cells from the ordinary tissue cells, and classification of the different types of cancer and tumour growth can be made.

Cancer seems to be a local rebellion of a group of cells against the established order. The rebellious cells are unrestrained in their action; they are "bolshevists", and if the local riot is not promptly checked it may develop so as to destroy life.

The cause of this untoward action on the part of the errant cell is unknown. Cancer is non-infectious; it is not hereditary; it is not introduced from without; it is generated within the body. There is no true germ or parasite to which the growth of cancer can be ascribed. Cancer itself is a parasite grafted upon the human organism upon which it acts in a destructive fashion.

Cancer may be a combination of diseases. Fifty years ago fever was a term used to cover a large variety of affections. The cause of most of

these fevers having been discovered, they are now classified as typhus, and typhoid fever, pneumonia, malaria, etc. Many physicians believe that cancer is similarly a general term that may cover a variety of diseases. It is well known that there are several types of cancer of the skin for example, and it may be that the light of future knowledge will separate cancer into its component parts, and aid in the solution of its control.

Pre-cancerous Growths

In addition to the true cancer there are other forms of irregular growths known as benign tumours. These are all more or less associated with malignant or cancer tumours but are comparatively harmless in themselves. There are cell processes which precede true cancer and which are known as pre-cancerous conditions. These pre-cancerous reactions of tissue cells appear to be due to the influence of some external irritant or of some internal stimulus. Some of these growths result in cancer, and most cancers develop from some such primary overgrowth of cells. Thus it appears that there is a stage in the life history of cancer when the growth, while a departure from the normal, is not actually cancer. Examples of this are seen in the pearly appearance of the lip in smokers, in the white spots on the tongue or inside the cheek, or in the scaly accumulations of epidermis on the faces of elderly persons. These are not cancer; they are pre-cancerous conditions which may and frequently do, become cancerous.

The Origin and Cause of Cancer

As already pointed out, no real cause of cancer has so far been discovered. All the causes which we know of are predisposing or exciting conditions which appear to be related to the origin of cancer. These include:

1. Hereditary predisposition.
2. Age.
3. Embryological faults.
4. Irritation and injury.
5. Biochemical stimuli.
6. Diet and civilisation.

Heredity—In both animals and men there are those whose susceptibility to

cancer is stronger or weaker than is the case with others. As in tuberculosis and many other affections the tendency to acquire the disease is higher in some than in others. Such persons are relatively more susceptible than other persons, their resistance to the particular affection is less, the soil is more favourable to the growth of the disease. The hereditary predisposition to cancer is, like that of tuberculosis, the true conception. There is no evidence that cancer is transferred from parent to child.

Age—Age is a definite factor in the onset of cancer. While malignant growths may originate at any age, the liability to cancer increases with the years of life. The work of preventive medicine has extended the length of life of the individual. Through this extension there is provided an additional number of potential cancer victims. The newer countries with a younger population have less cancer than the older civilisations. As the population becomes of more advanced age, the mortality of cancer increases.

Embryological Faults—The human body is a complex and wonderful structure. Its elements are the product of a single cell. As in all structures there are "faults" in the body construction, and it is not uncommon for a tumour to grow from one of these faults. Only a few of such growths are dangerous; most of them are innocent. The great cancers of the body, as a rule, take their origin from mature cells but now and then one develops from an embryological fault.

Irritation and Injury—It is not known how irritation acts in exciting the growth of cancer, but there is no doubt that injury and chronic irritation of a part often induce cancer. The surface of the body and the alimentary canal are among the chief sites of cancer. These regions also are the most subject to irritation. Many chemical and physical agents are known to excite cancer. Irritation is the commonest "cause" of cancers of the parts of the body subject to

injurious influences. Knowledge of this fact is of assistance in the prevention of cancer. Avoidance of irritation or the removal of irritating agents are potent measures in the reduction of cancer.

Biochemical Stimuli—The human body is a complex chemical laboratory. The growth of glandular cancer, and perhaps of other forms, is probably excited by the influence of the chemical processes of the body. In this field research may possibly uncover the real cause of cancer.

Diet and Civilisation—Since cancer occurs alike in vegetarians, in meat eaters, and in those using a mixed diet, the kind of food consumed has probably no effect in originating cancer. No diet will predispose to, nor prevent cancer in the individual. But the manner in which food is used may cause irritation, and thus excite a malignant growth. Foods taken too hot, or bolted without proper mastication may act as irritants or cause indigestion, and so provoke cancer of the stomach or intestines. Nor can civilisation justly be blamed for the induction of cancer. Certain civilised habits, higher life development and the greater average age of civilisation may account for the possible excess of the cancer of civilised people over that of primitive people. It is obviously impossible to disown the advantages of civilised life and assume primitive habits. The remedy is rather to gain control of cancer by research and application of scientific knowledge.

The Growth and Spread of Cancer

As already indicated, cancer grows by the proliferation of its cells to form additional cancer cells and that cancer spreads through invasion of adjacent tissue by the cancer cells or by their dissemination through the lymphatic vessels and blood vessels to distant parts. The spread of the original growth to other parts of the body is known as metastasis. The great danger in cancer comes from this invasion. The rate of this invasion and the destructive effect of the invading cells vary greatly in different cancers, and thus some cancers are much more dangerous than others.

The time for successful action is limited. Diagnosis and treatment, to be satisfactory, must be applied at the earliest opportunity.

Destruction of a small cancer at its beginning, or removal of irritation and continued observation of pre-cancerous states would do much to limit the mortality of this dangerous disease. This, and the fact that a neglected cancer will grow and infect the surrounding tissues, are additional arguments for the complete eradication of cancer at the earliest moment.

Decline and Death of Cancer

A cancer is a living thing, and like all living things it cannot last forever. Dr. David Arthur Welsh, F.R.C.P., Edin., writes in a fascinating manner of this and other epochs of the life history of cancer. He says:

"A few cancers reach the term of their natural life before they kill the patient. Every doctor who has had much experience of cancer can recall instances where a cancer appears to have been checked in its malignant career, where it has ceased to grow and where it has died out. What sometimes happens is this: the doctor declares with truth that an advanced cancer is hopelessly inoperable, and that he can do no more: the patient in desperation tries some quack remedy. Then the incredible thing happens; the cancer begins to die and the patient begins to live again. Not one in 1000 cancers, perhaps not one in 10,000, is it so obliging as to die before its human host."

But the incredible fact has happened through the cancer possessing a low order of vitality or because of the high resistance of the body, and this fact is encouraging in that research may discover a means of accelerating the exhaustion of cancer vitality or of increasing bodily resistance to malignancy.

The Signs of Early Cancer

The early signs of cancer are frequently obscure. In many there is no apparent tumour. Most of them are painless. They are painless until their size causes pressure on nerve filaments, or interferes with the function of an organ. But usually there

are danger signals. There is a sore, say on the lip, the tongue or the inside of the cheek, which fails to heal; there is the red flag of hæmorrhage from the lower bowel or the internal organs of women; there is the lump in the breast; the continued hoarseness from a growth in the larynx; the protracted indigestion which fails to respond to the usual remedies. These are facts which should be matters of everyday knowledge. Any of these signs should be regarded with the gravest suspicion and every opportunity taken to prove or disprove their association with cancer. Neither patient nor doctor can afford to gamble on the chances that any single one of these signs is an innocent one. Nothing should be left to chance. Every available means of diagnosis, under such circumstances, should be resorted to and the investigation of such signs should be pursued until the question of cancer or no cancer is solved.

It is a very great misfortune for the human race that cancer in its early stages is often unaccompanied by pain. If cancer were only as painful as a toothache from the start, thousands of those who procrastinate until the disease is too far gone for curative measures, would be relieved of their troubles and cured of their disease.

Modern Methods of Treatment of Cancer

The chief resources in the treatment of cancer are: surgery, x-rays, and radium.

Of these resources that of surgery has long held the field, and surgery remains the most potent agent of treatment in cancer of the stomach, of the intestines, the fundus of the uterus, and other abdominal organs, though this field is being somewhat invaded by irradiation either as an active or as an auxiliary to surgical treatment: it is still the best resource in cancer of the larynx and esophagus, but in these fields also radium is taking a part. In treatment of cancer of the breast, surgery holds the chief place. Here again radium and x-ray are widely used in auxiliary treatment

and are considered by some clinicians to be the best method.

In cancers of the surface of the body, the lips, buccal cavity, the jaws and throat and the uterine cervix, radium and x-rays afford very satisfactory results, especially if cases are seen early, a requisite that widely enhances the opportunity of cure by any method. It appears, therefore, that for the largest number of cancers of the human body, surgery is still the method of choice, but it is equally apparent that both radium and x-rays are powerful and effective methods of treatment, and that facilities for treatment of cases should include the best in all three lines.

In addition to those methods there is a variety of therapeutic measures such as various serums, the use of colloidal lead, etc., the results from which are, so far, too remote as seriously to enter into competition with the proven results of the well-known triad mentioned. What the future holds in the direction of new treatment of cancer, it is impossible to say. It is the hope of everyone that simpler and even more effective therapeutic agents in cancer treatment may, ere long, be discovered.

Surgery—In an address of this nature it is unnecessary to dilate upon the value of surgical treatment. This form of treatment since the days of the immortal Lister has shown an extraordinary development, and some of the most prominent surgeons are of the opinion that its limits as a therapeutic measure have almost been reached. Surgery still holds the field in cancer treatment; the surgeon has reached an astonishingly high degree of skill: he is confident of himself, and it will only be by a discovery of newer, more exact, and simpler methods that he will be dethroned.

The limited time in this address given to the consideration of the surgical treatment of cancer, fails to indicate the immense value of surgery as a therapeutic agent in malignant growths. The surgical treatment of cancer is so well-known both within and without the profession

that it seems out of place to say more than that, in our present state of knowledge, surgery still holds the premier position; it is still the line of approach in the majority of cancers.

Opinion of the value of early surgical measures in cancer, is given by Lord Moynihan, one of the most distinguished of British surgeons, as follows:

"No better illustration of the value of early surgical interference in cases, for example, of cancer of the breast could be given than the statistics published three years ago by our Minister of Health. Very briefly, it was found that when the operation for cancer of this organ was performed in the early stage of the disease, 90.1% of women were alive and well ten years after operation, whereas if the disease was very advanced, 94.4% were dead within this period. The nature of the disease was the same, the operation the same; the stage of the disease made all the difference. It is true to say that every single case of cancer where the disease is accessible to the surgeon, is curable in the early stage, for cancer is at first a local disease. It is quite obvious, therefore, that the future success of surgery very largely depends upon the education of the public in these matters and of a very clear recognition of that fact that their only fear should be the fear of delay."

Radium—Radium is a radio-active substance derived from pitch-blende, the chief source of which is the Belgian Congo. In 1896 Becquerel discovered that the element uranium, the important constituent of pitch-blende, emitted rays capable of passing through material substances, and a little later M. and Mme. Curie proved that these rays were produced by the disintegration of the uranium atom, that a new element which they called *radium* was formed, and that this in its turn was subject to continuous disintegration, during which similar rays were emitted.

The total (approximately) of radium available in the world is 25 ounces. The United States owns 50 grams, the British Isles 60 grams, and France 50 grams.

Radium is used in two forms, first as the element which in appearance resembles white pepper, and, second, in solution from which an emanation or gas called radon, is produced. The dose in each form can be accurately measured and is usually referred to as so many milligrams of radium element.

The disintegration of radium is a slow process, one half disappearing in a period of 1690 years. Its final disposition is lead. During the process of disintegration energy is liberated in the form of alpha, beta and gamma rays. The emanation of radium is a gas which will be lost unless the radium from which it arises is kept in a sealed receptacle. In the sealed container radium emanation gradually accumulates in an increasing amount, and it is used chiefly in the form of "seeds", which are tiny sealed receptacles of gold or other material, and which may be inserted into or about the growth, the time employed and the quantity used constituting the dose. In a little less than four days the emanation (radon) loses half of its strength.

Radium is very expensive. Its production at present is chiefly in the hands of the company called the Radium Belge, with headquarters at Brussels. The company's works are at Oolen, near Antwerp, and the operation of transforming pitch-blende to radium, requires 67 processes. In the production of one gram, some 80,000 tons of rough material and large quantities of chemicals are handled.

The effect of radium element, of the emanation and of x-rays, is much the same, and preference for one or the other, is chiefly a matter of convenience, accessibility of the growth, and personal experience. For the treatment of tumours, the hard or gamma rays are used, the softer rays being cut off by a filter of lead, platinum or other metal. The reason why these rays, in appropriate dose, destroy cancer cells, and at the same time have a minimum effect upon normal cells of the body, is largely because the cancer cells are in a

constant state of division and are, consequently, more sensitive to the rays than normal cells. In addition to this, the rays are believed to have an effect upon the surrounding tissues, which contributes to the cure of cancer.

Both x-rays and radium in excessive dose, are very dangerous, so those in charge of treatment must use the greatest care in prescribing the dosage used, and in adopting safeguards necessary to the protection of both workers and patients. The use of irradiation, whether from x-rays or radium, demands prolonged experience and meticulous care. It is a form of treatment that can only be successful and be carried out safely in an institution for the purpose, in the hands of skilled operators; it is NOT one for the general practitioner. Everywhere this fact must be stressed. The rays of radium and the Roentgen rays are invisible, potent agents for good when properly used; they are dangerous in the hands of persons unskilled in their use.

Roentgen or X-Rays—On November 8, 1895, a new kind of ray was discovered in Wurzburg, Bavaria, Germany, by Prof. Wilhelm Conrad Roentgen, Professor of Physics in the University, a Doctor of Philosophy.

For the first time was seen a light never before observed on land or sea. It was a faint, greenish illumination upon a bit of cardboard, painted over with a fluorescent chemical preparation. Upon the faintly luminous surface was seen the line of dark shadow. The experiment was carried on in a darkened room from which every known kind of ray had been scrupulously excluded. A Crookes's tube stimulated internally by sparks from an induction coil was provided and carefully covered by a shield of black cardboard impervious to every known kind of light. Nothing was visible until the hitherto unrecognised rays, emanating from the Crookes's tube and penetrating the cardboard shield, fell upon the luminescent screen, thus revealing the new rays.

The visible rays, they were invisible until they fell upon the chemi-

cally painted screen—were found to have an enormous penetrative power, passing through cardboard, cloth and wood with ease. They would go through a thick plank or a book of 2,000 pages. But copper, iron, lead, silver and gold were less penetrable, the densest of them being practically opaque. White flesh was very transparent, bones were fairly opaque, and so the discoverer, interposing his hand between the source of the rays and the luminescent cardboard, saw the bones of his living hand projected upon the screen.

The x-rays have much the same effect as the rays from radium. They are really the same thing but can be used where the local situation of the growth prevents the ready application of radium.

In certain places in Germany, for example, cancers of all kinds are treated with x-rays, the projector of the rays being forced in close to the growth, in the abdomen or breast, just as one can force one's fist into a soft pillow. Both the rays of radium and x-rays can be accurately measured, there being an international "yardstick" for this purpose, thus allowing of the dose in one country being the same as in another.

Neither radium nor x-rays are cure-alls: they are auxiliaries to surgery in the treatment of cancer, with the fortunate exception that in cancers of the mouth, throat, lips, skin and the uterine cervix, they are probably better methods of treatment than surgery.

Hopes for the Cancer Patient

Thousand of reports of cancer have been accumulated all tending to show that this disease of humanity is almost never hopeless; that cures have been obtained in seemingly the most futile cases, and that the greatest obstacle to the improved treatment of the disease is the mental lethargy and the hopeless attitude of the general public.

This public condition can be changed only by education, by the use of the true facts about cancer, by the spread of knowledge as to newer and improved

methods of treatment and by urging the public to present themselves to the physician not when the earliest signs appear, but yearly after 35 years of age, just as they visit the dentist.

Prevention of Cancer

Prevention of cancer may be achieved to a considerable degree by the education of the public and of doctors, nurses and dentists in the early signs of the disease.

It is a lamentable fact that, all over the world, one sees the majority of cases coming too late for treatment. There is a fear of cancer. The only

tear should be the fear of delay. Education in the early signs of cancer will be of service; the great hope is the public health education of the child. In this work every professional unit can assist; the doctor, the dentist, the teacher and the nurse. There must be wide publicity, through the press, by radio, by exhibits, by lectures, pamphlets, and by personal contact. These will cost money, but no money could be more wisely spent. The periodical health examination, like the yearly visit to the dentist, would save many lives.

What the Nurse Can Do in Cancer Control

The trained nurse as we know her, is a comparatively modern institution, whose duties lead her to an infinite variety of work, for which she was not at first designated. Trained at the outset for the care of the sick alone, the field of the nurse has become broadened so that she is now widely engaged in the work of preventive medicine. Her first essay in this direction was among school children in the effort to limit the spread of infectious diseases. The employment of school nurses is barely thirty years old, and at the moment there are approximately 6,000 nurses so engaged in England alone. This field of work has become widely extended in most countries and embraces not only the prevention of infection among school children, but also the control of tuberculosis, of home visiting, the welfare of the school child and of the mother and family. The factory has been invaded and an effort made to protect the worker by first-aid, and in the control of occupational diseases. Briefly, the sick nurse has become a public health nurse whose arena of action lies in the vast field of preventive medicine.

Cancer is a disease in which high service may be done in prevention. There are many pre-cancerous conditions, the danger-signals of which are readily seen. There is the red flag of irregular hæmorrhage, the unhealing sore on mouth, lip or else-

where, the lump in the breast, intelligence of which usually reach the nurse before anyone else.

The trained nurse, because of her education, her sympathy, her devotion to duty, and the confidence she inspires, is perhaps the best public health educator. The training of the modern nurse leaves little to be desired; her sympathy is the proverbial sympathy of women-kind, she gains a confidence from women akin to that possessed by the family doctor: her devotion to duty is never questioned. She is, particularly in respect to her own sex, in a position to be of the greatest service in cancer control.

May I suggest that the nurse should cultivate this field of preventive medicine, that she should learn as much as possible about cancer and that she should embrace every opportunity of spreading among her clientele methods of prevention.

In concluding may I refer to that great Memorial of the War in Edinburgh, which some of you have no doubt seen. On the western wall is a bronze tablet depicting the work of the nursing services, and beneath the lines:

"They shall not grow old as we that are
left grow old,
Age shall not weary them, nor the years
condemn,
At the going down of the sun and in the
morning,
We shall remember them."

Editorials

AN APPRECIATION OF TRUTH

A sale of fourteen hundred copies of the Survey Report in one month after publication! That is the unprecedented record of the purchasing power of Canadian nurses. Searching for the reason for such interest, one is compelled to recognise that through the years there has been an evolutionary process going on quietly but effectively. Out of the time when the nursing group was inclined to accept the *status quo*, somewhat resenting adverse criticism, has evolved the present-day attitude: one of increasing appreciation of revealed truth.

Admittedly the Survey has been a purposive and comprehensive attempt to ascertain and appraise existing conditions. Those who have read the Report with care are aware that in spots it cuts deep. Fearlessly but sympathetically and constructively it penetrates to the core of nursing problems. The result is an unearthing of conditions, some disquieting, others encouraging. True it is that some recommendations are open to controversy. It would be phenomenal and probably unhealthy to find any such work with the conclusions of which all could agree totally. The biennial meeting of the provincial associations will do justice to the controversial aspects of the Report.

The present interest of the writer, though profoundly impressed with the quantity and quality of information presented, is not that but rather the attitude of the nursing group toward existing facts. On the whole, it is magnificent. The determining factor is not so much the gravity of some aspects of truth revealed, but the spirit of the profession in facing the facts. There are signs of a broadened outlook, of the gaining of a truer perspective. In short, evidence is not wanting that there is an acceptance and appreciation of truth. If that be

the case, a long step has been taken toward a goal that will be reached eventually.—F. H. M. E.

THE SURVEY REPORT

It was with eager anticipation Canadian nurses awaited the release from the press of the Report of the Survey of Nursing Education in Canada. Now that copies are available, we know we are expressing general opinion when we state that we are justly proud of the appearance and contents of the Report.

It was in June, 1927, at a specially arranged conference of representatives from the Canadian Medical Association and the Canadian Nurses Association, called to determine on procedure in making a study of nursing conditions in Canada, that it was decided some constructive action should be taken in an effort to secure accurate and detailed knowledge of nursing in Canada from the standpoint of the nurse, the doctor and the public which is served by both professions. A Joint Study Committee was appointed, composed of six members: Miss Jean Gunn, Miss Kathleen Russell and Miss Jean Browne, who became secretary of the committee; Dr. A. T. Bazin, Dr. Duncan Graham and Dr. G. Stewart Cameron, who was appointed chairman.

Following intensive consideration of the whole question, this committee unanimously agreed that the situation demanded a thorough study from coast to coast and that a competent person experienced in the direction of such investigations and belonging to neither of the professions directly interested, should be secured. The committee was fortunate in obtaining the services of Dr. G. M. Weir, head of the Department of Education in the University of British Columbia.

At this early date we dare not presume to express full appreciation of the Survey contents. The Report is a colossal volume that will take months to study before we can voice a detailed opinion on its contents. The Director, Dr. Weir, was given the following directions from the committee: "Get at as many facts regarding nursing conditions as possible, interpret these facts in the light of the most approved educational and sociological principles: do the work thoroughly and for all Canada." In the Preface, Dr. Weir states that to have followed those instructions to the letter of the law, his study might readily have extended over a period of four or five years.

His report, including field work, was accomplished in approximately eighteen full months, and while it may not represent the degree of thorough investigation resultant of a longer period of study, the report reveals that he has given Canadian nurses a vast compilation of facts, coupled with an unbiased discussion of the principles involved. Dr. Weir has accomplished his work for the C.M.A. and the C.N.A.; the national Joint Study Committee can view with assured satisfaction the accomplishment of the aim outlined over four years ago; future action rests with ourselves.

We owe a great debt of gratitude to Dr. Weir; we are justly proud of the members of the C.N.A. who have given so lavishly of their time and ability in co-operation with the representatives of the C.M.A. on the Joint Study Committee; we express our sincerest thanks to them. But the best way by which Canadian nurses can demonstrate their appreciation of what has been done for them is by procuring copies of the Report—its appearance alone is worthy of a prominent place on one's bookshelf, better still among one's often used reading section—and by an earnest and determined study and application of the recommendations made by the Director. Should we do so, and uni-

tedly endeavour to improve nursing education and nursing conditions, there is not the slightest doubt but that nursing and nurses in Canada will take their place as one of the nation's greatest assets. Can we do that?

We thank Dr. Weir and the members of the Joint Study Committee. These words seem small, but behind them there is a gratefulness that will linger throughout the months and years as members of the Canadian Nurses Association continue to demonstrate their solidarity of purpose.

THE LANCET COMMISSION ON NURSING

Our readers are aware that studies of nursing education and nursing service have been carried on simultaneously in England, in the United States and in Canada. The study in England was initiated by *The Lancet*, a medical journal, first announcement of which was made early in November, 1930.

Editorial comment on the Second Interim Report of the Lancet Commission, made in the October number of this *Journal*, stated that probably the final reports of the studies in England and Canada would appear about the same time. An interesting coincidence is that the Lancet Commission Report was released within a day or two of the Survey Report in Canada.

In the United States the second grading of schools of nursing is well under way and recently the Director of the Grading Committee announced that a surprisingly large number of the 1744 schools that took part in the first grading have already sent in their forms.

Copy of the Lancet Commission Report was received in Canada too late for more than brief mention in this issue. The Report can be ordered from *The Lancet*, 7 Adam Street, Adelphi, London, W.C.2, England. Post free 2s. 9d.

Manic-Depressive Psychoses

By A. L. MacKINNON, M.B., Homewood Sanitarium, Guelph, Ontario.

The Manic-Depressive Psychosis is the most picturesque form of mental disease. It derives its name from the fact that both depression and mania may appear in one individual. This may happen in any one of three ways:

(1) One phase may follow immediately on the heels of the other.

(2) An attack in which only one phase is seen may be followed years later by an attack illustrating the other phase.

(3) Some of the symptoms of depression and mania may occur simultaneously as seen in the so-called mixed type.

The first of these three is the type most commonly seen and the third is the most unusual. It should be added that a great many individuals suffering from manic-depressive insanity are afflicted with only one phase of the disease, i.e., they suffer from mania without ever being depressed or suffer from depression without ever being excited.

Etiology

As is the case in many other forms of mental disease, the etiology is obscure. The most commonly accepted view is that the individual who suffers from this disease has been born with a constitutional mental weakness and consequently heredity comes in for a major share of the blame. At any rate, it is common to find a history of mental disease, epilepsy or alcoholism in the immediate family of a manic-depressive patient. There are, of course, precipitating factors that must receive consideration. The commonest ones may be cited as follows:

(1) One or more serious physical illnesses or injuries.

(2) One or more shocks in the form of sudden deaths in the family, occurrences leading to social disgrace, etc.

(3) Economic crises or other purely environmental factors.

(4) Any constant worry, especially if considered too private to be discussed with other individuals.

Patients frequently have shown abnormal trends for years before suffering from a definite attack. Common examples are emotional instability, the "high-strung" temperament, defective judgment, uncontrollable temper, a tendency to extreme "ups" and "downs," alcoholism and undue worrying. It must be remembered that these conditions are not the cause of the subsequent "breakdown" but merely early manifestations of a tendency toward mental disorder.

Symptomatology

I. The Excited Phase: The onset is usually gradual, though the significance of the early symptoms is commonly missed by the relatives. The result is a history of a somewhat sudden and startling onset. By questioning relatives or associates closely regarding the period preceding the frank symptoms, one learns that the individual has shown a deviation from his normal for weeks or months. The change in personality most commonly noted is toward egotism, euphoria, over-activity in both mental and physical realms, marked sociability, easily aroused temper, inability to concentrate, poor judgment, extravagance, etc.

When the disease has reached its zenith the above symptoms are greatly magnified. The sense of self-importance is so great that definite delusions of grandeur are present. The patient considers himself possessed of great physical and mental ability, is very wealthy—talking in millions, or comes of a very noble family. Power of concentration is almost nil and the mind quickly wanders from one subject to another. There is usually some clouding of consciousness which amounts to deep confusion in the most severe cases.

There is some degree of disorienta-

tion, especially in the personal sphere. Patients will invariably call strangers by the names of people they have previously known owing to slight resemblances in appearance which the normal individual would fail to notice.

The intelligence is sharpened in the mild and moderate cases; in fact, the wit of the manic is proverbial.

Emotions are unstable—friendly one minute and antagonistic the next, and the same rapid change from laughing to crying. Hallucinations are noted only in the more severe cases, and are usually of the auditory type. It is not uncommon for a patient to pretend he hears voices and sees visions in which case he brags about them. In the physical realm one sees insomnia, lack of appetite, loss of weight and rapid pulse. Such symptoms are usually secondary to the mental disturbance.

The picture which one carries away after seeing an acutely excited patient is that of a very mischievous and likable individual who is constantly on the move, talking incessantly about everything or anything, frequently swearing, shouting, singing or rhyming. His expression shows his excitement. His room and person are untidy and often decorated in a bizarre fashion with coloured pictures or anything available. In the most severe cases, the patient is destructive to clothing, furniture, dishes, etc., and often violent to those about him.

II. The Depressed Phase: Here also the onset is gradual but one must imagine a set of symptoms which are the direct antithesis of those seen in a manic attack. There is a gradual lessening of mental and physical activity, a feeling of unhappiness creeps over the individual, so that he does not want to be seen. Ambition and energy gradually diminish so that interest in the ordinary affairs of life is lost. Worry is almost continuous and it is amazing how readily something is found about which to worry. One worries about

financial matters, another about his physical health. One is uncertain about the welfare of his soul and another is afraid that his relatives are all dying. There is great variation in the severity of the attacks, and a good deal of variety in the symptoms. In the severe cases the above features are accentuated and besides we see delusions of unworthiness and wrong-doing, with which is associated a tendency to suicide. We see mental confusion in varying degrees and knowledge of time and location are often lost. Auditory hallucinations are not uncommon, the patient frequently stating that people are talking about him. There is often fear of impending disaster. Besides these purely mental symptoms, there are physical disturbances such as loss of appetite, loss of weight, insomnia, change in pulse rate—slower in the retarded types but always rapid when there is agitation. Stubborn constipation is the rule.

It is difficult to engage the depressed patient in conversation, but when he can be induced to talk the burden of his remarks will be: "I am not sick, my condition is the result of sin, I am getting worse each day, I will never be myself again, and it is useless to try to do anything for me." One woman says she has committed the unpardonable sin by blaspheming the Holy Spirit, another says her habits have caused suffering to all about her.

Course

The majority of cases reach the peak of severity in the course of a few months from onset of first symptoms. The acute stage usually lasts two to four months and this is commonly followed by a prolonged convalescence. Recovery frequently occurs by a series of steps with intervals in which there is no improvement and often retrogression is seen. Sudden recoveries are very spectacular but unfortunately are rare. There is great variation in the duration of the attacks in different people, but usually it is a matter of months

and often a year or more before recovery is complete.

Prognosis

As a rule cases of manic-depressive insanity without complications recover. There is always danger of a recurrence of the disease. There is no rule to govern the frequency of the attacks; the interval between may be anywhere from one to twenty-five years. Patients in later years of life may pass from one attack to another without fully regaining health at all. The second and subsequent attacks are apt to be more prolonged than the first, and the periods of good health become shorter. Some cases seem to go through a definite cycle—one woman in our experience has had a manic attack regularly every twenty-four to thirty months for the past twelve years. The manic phase reaches the height of its severity in about one month from date of first symptoms. She remains in the acute stage for four to six months and is mildly elated for two or three months. This phase is followed by a spell of mild depression lasting two or three months. This leaves twelve to eighteen months of normal health before the next attack.

Preventive Treatment

While the foundations of the personality are laid before the individual is born, still much can be done to prevent disaster by careful management on the part of intelligent parents, teachers, physicians and others who exert a powerful influence. It is impossible to lay down rules enough to guard against every pitfall and for the most part we must depend on sound common sense, leaving a good deal to Mother Nature. Discipline is essential, especially self-discipline which the child learns best by example, but it is easily overdone with the result that we see a child with the initiative frightened out of him or a stubborn individual who has become heartily sick of all authority. Unfortunately, preventive treatment usually begins after the first attack

has caused considerable damage. It is then that a superabundance of tact is required in order to guide and control the sufferer without his knowledge. If he appreciates the nature of the illness through which he has passed he will be willing to take steps to prevent a recurrence. Many patients look back upon a manic attack as a minor incident which resulted from abuse at the hands of relatives or business associates. These people present a difficult problem. Although no form of preventive treatment will be applicable to every case, one should endeavour to induce the subject to lead a well balanced life which merely means—steady work, regular exercise, a sensible diet, a moderate amount of recreation and avoidance of excesses of any kind—in work, in the use of alcohol, in the observance of religious rites.

People showing a depressive tendency need encouragement, extra food and extra rest. The feverish efforts of friends to "cheer up" this man are definitely harmful. He is unable to do as much as the healthy, energetic person and should not be asked to attempt it.

General Principles of Treatment

It is useless to say much about the treatment of excited cases in the early stage. It usually takes some time for the relatives to realise that there is really any mental change and by the time the symptoms have advanced to the point where they are recognised as such, the patient is almost out of hand. What he needs is control and supervision, but any attempt at this usually results in rebellion. The final break is usually precipitated by an orgy of extravagance such as buying a house, a business or an aeroplane at an exorbitant figure, or the giving of costly presents to anyone and everyone, or some incident in which the patient runs foul of the law. Incidents like these usually bring home the fact that the time has come for institutional care. This is usually arranged for as speedily as possible, two practising phy-

sicians examining the patient and completing the necessary certificates. The relatives make the financial arrangements and place the patient in a mental hospital. Once in the hospital, treatment is easier because the patient can be kept under control. The common measures used in order to control excitement are continuous baths, hot packs and in some cases sedative drugs. In most cases drugs merely add to the mental confusion without controlling the excitement. One of the most essential points in the treatment and often the most difficult, is the administration of a sufficient quantity of liquids and nourishment to fulfill the bodily needs. Nourishing liquids should be given every hour, as acutely excited patients do not have time to sit down and eat a full meal. Elimination, of course, must be watched closely. In the milder cases and in the convalescent stage of the most severe cases, massage, exercise under supervision, occupational therapy and as many forms of recreation as are feasible, are of great help.

The treatment of the depressed patient is necessarily somewhat different from that of the excited individual, but here again the early symptoms are not considered indicative of mental disorder. Frequently one hears not only the layman but the physician say of the mildly depressed patient "All he needs is to be cheered up" and not infrequently that more radical form of treatment known as a "swift kick" is prescribed by kind and sympathetic friends. From a psychiatric point of view, the treatment of these cases is somewhat different. The patient is encouraged to take plenty of exercise in the fresh air, to eat frequently, and to indulge in a moderate amount of recreation. At the outset one attempts to explain to him the nature of his illness, at the same time giving a sympathetic ear to the expression of his many worries. In those cases which gradually become more severe, it is frequently the threat or fear of suicide

that finally leads the relatives to arrange for institutional care. There are, however, many severe cases of depression in which suicide does not seem to be at all likely, but it is necessary to have experienced nurses to take charge of the patient's feeding and other essential matters relating to their care. The deeply depressed patient should be kept in bed, especially if there is any great degree of agitation. In those individuals who are reasonably robust physically continuous baths may be used. Often the patients are severely debilitated so that one hesitates to exhaust them still further with this form of treatment. I think there is no doubt that the most important point in the treatment of these cases is the administration of an ample amount of nourishing fluids. Massage, hot packs, dry packs, tub baths, all help to soothe the patient. Sometimes music or reading to the patient often has a beneficial effect. In the less severe cases, a gradually increasing amount of exercise in the fresh air, occupational therapy, organised games and other forms of recreation are found very helpful. So far I have said nothing of the treatment of that troublesome symptom, insomnia. At first one always tries to overcome this by fresh air and exercise, baths, massage, packs, warm drinks at bedtime and through the night, but in many cases these measures do not bring results, and the use of one or other of the mild sedative drugs gives the patient the desired rest so that he is able to carry on more satisfactorily with the next day's regime.

In conclusion I want to say a more personal word on behalf of the mental patient. It is most important for all those on whose mercy he depends to remember that first of all he is a human being, that his weaknesses are only the weaknesses of us all, temporarily exaggerated. Often his powers of observation are more keen and he is more sensitive to any word or action which may help or discourage, than is the so-called nor-

mal individual. It is easy to develop the attitude that it does not matter how one treats or what one does for a mental patient, because he may not know what is going on and does not appreciate the kindness shown him. As a matter of fact, the manic depressive patient has an exceptionally keen memory and long after he

is well can relate in accurate detail practically all the incidents associated with his attack. If he does not thoroughly appreciate what is done for him when he is ill, that appreciation comes with recovery, and expressions of gratitude are heaped upon the individual who has been kind and sympathetic throughout.

The Nursing Care of Manic-Depressive Insanity

By EMMA PETERS, Homewood Sanitarium, Guelph, Ontario.

In order to give our patients the best of nursing care, it is important that we acquaint ourselves with all details of their condition. Each case of manic-depressive insanity differs from another but there are some important routine measures. Some patients suffer from repeated attacks of the manic phase of this disease, others from alternating attacks of the manic and depressive phase and others again, from the depressive phase only. For the sake of simplicity, I shall endeavour to describe the general routine measures for each phase separately.

The Manic Phase

On admittance to the hospital, it is a rule to put the patient to bed in a room where quiet is possible and all sources of sense stimulations are reduced. This bed period, of course, varies in length of time with the case. In the nursing-care of excited patients we have to deal with a number of conditions. The one most noticeable at first meeting is, probably, described best as motor-hyperactivity. The means of dealing with this condition depends upon symptoms. In years gone by, restraint in various forms was much employed but this form of treatment has gradually been discontinued and many hospitals today do not permit its use. Hydrotherapy has been substituted with gratifying results. In hospitals where it is still employed the rules, governing its use and application, are very strict. The forms which are authorised are prescribed as well as the duration of the treat-

ment and the keeping of records regarding the same. Only in extreme cases where the patient becomes a danger to himself and to other patients, the physician orders the application of the protection or safety sheet. This allows some freedom of movement and at the same time controls the aimless, violent activities. Quite often, the patient is so exhausted that he will go to sleep soon after being placed in the protection sheet and will wake up quiet and manageable. During this treatment, the patient must be watched carefully, pulse and respiration noted frequently, water given freely, face and neck bathed with cold water and ice applied to the head. After removal from this pack, the patient is given a bath and fresh gown and is placed in a newly made bed.

Continuous baths are usually prescribed by the physician to aid in reducing excitement. For this purpose a special apparatus is installed in each modern hospital for mental diseases and each nurse is taught the proper use and application and care of the patient before, during and after the treatment.

The danger of excitement is progressive weakness due to sleeplessness and lack of food for both of which such patients are often "too busy." The question of diet is very important, to quality as well as to quantity. Much time and perseverance are required to accomplish results. Large quantities of fluids are particularly desirable. Often, the nurse has to resort to spoon-feeding.

Proper elimination and sleep must be secured. The nurse should exhaust every means at her command to induce sleep before making use of the drugs which have been conditionally prescribed by the physician.

Special care must be given to mouth, tongue, teeth and lips as many of these patients talk or sing continually. The usual baths will tend to relieve the dryness of the skin. The finger-nails should be closely trimmed to prevent scratches.

One main object in the nursing-care of excited patients is to bring their disordered conduct into more normal channels. In many cases, the nurse can direct their use of energy by suggesting some other form of activity. Only those forms of work which make use of the coarser movements should be attempted: tearing rags for rugs and rolling them into balls, knitting on large needles with coarse yarn, brushing the floor, pushing the floor-polisher or, perhaps, some work outside, digging, raking, rolling the lawn or any outdoor or indoor sport, music and dancing.

Associated with motor-hyperactivity we find mental hyperactivity. Patients' thoughts rush headlong and they have what we call a "flight of ideas." As a rule, these patients have a marvellous memory. It is best that the nurse's answers to the patients be studied and consistent and that she avoid fruitless arguing. A good rule is to approach them with calmness and quiet dignity. They are observing and imitative. It is often advisable to let them write, perhaps, on their own life history or some other subject that pleases them. It is easier to direct than to break their activity.

The manic patients' senses are over-strong and over-acute, therefore it is best to make their surroundings as simple as possible. Often on account of their tendency to strong likes and dislikes it becomes necessary to exchange nurses. Again, we meet with a tendency to "devilishness" when patients know

that they are looked upon as being irresponsible and act accordingly. Such patients must be made to feel that there is a power of control. Firmness and fearlessness can meet these tendencies. In cases where patients become violent, the following measures can be taken: Control of associations, to display no fear, to have enough help on hand and not to forget that the patient may secrete articles for weapons. One measure is restraint of which I have spoken before, and drugs.

The Depressive Phase

It is said that these cases are the commonest form of mental disease and I feel free to say that they are a sure test of a good psychiatric nurse.

The initial bed period varies with the case but is usually longer than in the case of mania, on account of the sub-normal physical condition associated with the disease. Since the state of mind is at the basis of the condition, it is well to cultivate a thorough understanding for the thoughts and feelings of depressed patients. The first impressions which they receive on entering the hospital are important. If the nurse can win their confidence in the beginning much is gained. Nearly all have some definite grief whether based on facts or on delusions. Contradicting them will not only help them but will also cause a withdrawal of confidence.

All actual nursing procedures are directed toward the building up of their physical condition. All physical functions are lowered or diminished and all symptoms have to be treated as they arise. Food is often refused because they think they do not deserve it or have no money to pay for it, or will deprive others who need it more, or have a desire to "starve to death." This problem taxes the resourcefulness of the nurse. It is of the utmost importance that they take a sufficient amount of nourishment each day. Frequently, this can be accomplished by spoon-feeding, but in some cases all measures fail and

the physician has to resort to feeding by tube.

Insomnia is one of the outstanding symptoms and must be combated by all available measures. These patients must be kept warm for sensation is often dulled and they will not complain of feeling cold. Massage is beneficial and often the salt-glow is prescribed. In many cases the physician will order electrotherapy to be applied for its stimulating effect. All secretions and excretions must be watched. Many depressed patients show agitated movements of restlessness. This condition is met by hydrotherapy, rest treatment and in extreme cases by drugs. Others suffer from psychic inhibition, a condition in which they cannot seem to sum up enough energy to do anything, often answer with some delay and show that it affords them some effort to think and speak. The recognition of this state of mind is important. The nurse has to make their decisions for them.

All depressed patients have a tendency to morbid thoughts and actions and it is of the utmost importance that the nurse never lose sight of the fact that each one is a possible suicidal risk. No depressed patient must be left alone at any time for the planning of suicide is the one most prominent and absorbing idea. Space forbids the enumerating of all methods and devices which are used to accomplish this end but I may say that by far the commonest methods are: strangulation, drowning and the severing of blood-vessels. It is imperative that vigilance be never relaxed and that all articles which the patient may have secreted for the purpose of self-injury or destruction be removed. This should be done in such a manner as to avoid the disclosure of distrust and lack of confidence. These patients should be cared for in bright, sunny wards or rooms and surrounded by an atmosphere of cheerfulness and hopefulness. The

best way to approach suicidal tendencies is an absolute frankness in entering the subject with the patient. Often, we get a clue to what might be done to prevent danger. Never should the nurse accept a promise of a suicidal patient and not forget that the time of greatest danger often is the day of removal from the hospital. This may be caused by a fear of another institution or a sense of inability to take their place in the world. When a nurse sees this, she should not hesitate to report it at once.

One of the most helpful nursing measures in the case of depressive insanity is the introduction of some suitable occupation. Precaution, however, must be taken to avoid fatigue, to avoid that form of work which in the patient's mind precipitated his breakdown and to avoid the danger of suicide by such instruments as scissors, steel crochet hooks or knitting needles, etc. These patients need much encouragement and frequent assurance that their work is being well done. Occupational therapy is in itself too large a subject and can only be touched on in this brief space.

A well known physician has said: "A cheerful, intelligent nurse of good judgment can do more for these patients than all the doctors and drugs in creation." I should like to add a few lines which seem to express what Dr. C. B. Burr calls: "The ethical and spiritual side of nursing:"

And last, not least, in each perplexing case
case

Learn the sweet magic of a cheerful face,
Not always smiling, but at least serene
When grief and anguish crowd the anxious
scene.

Each look, each movement, every word
and tone

Should tell the patient you are all his own,
Not the mere artist, purchased to attend,
But the warm, ready, self-forgetting
friend

Whose genial presence in itself combines
The best of cordials, tonics, anodynes.

(Oliver Wendell Holmes, M.D., 1849.)

The Romance of Nursing and Medicine

By FLORENCE COLE, School of Nursing, Galt Hospital, Galt, Ontario

When we examine the records of history we find that nursing, as we understand the art today, is really of very modern origin. However, there has ever been the need for the care of the sick, and this need had to be met and dealt with to the best knowledge and understanding of the times, crude though it may have been.

Most intimately have medicine and nursing always been allied, therefore it is necessary that we briefly trace the progress of each from primitive man down through the ages.

How could the "Ancient" conceive of his joints as levers, of his heart as a pump, of his lungs as a furnace? How could he imagine that the air was thronged with millions of little invisible ministers of disease? He might sacrifice to gods; he might carve and cook his foe, thus gaining some idea of the rough structure of the human body, but of the body in its relationship to physical laws he had no conception. And, if to the savage the body was a mystery, a half-apprehended possession, how much more were the body's diseases! What a bewildered creature he must have been; now paralysed by an invisible weapon, now convulsed by invisible forces; painted now red by measles, and now white by leprosy. Naturally, diseases with such mysterious causes required mysterious cures, so that offerings to the gods, and charms, and incantations must have seemed appropriate remedies. In the gods no thinker believed, but, as usual, thinkers were few and the mass of men clung to their superstitions.

To a few great scientific minds we owe all the real science of the world. Had we been left to form our own cosmic and physiological theories they, too, would perhaps be very weird and fantastic.

The oldest medical treatises known are the medical papyrus discovered

by Professor Flinders Petrie, near El Lahun, about 1872 A.D. (found between the legs of a mummy), dated about 1500 B.C., the Berlin Medical Papyrus, 1400 B.C., and others. Some of the cures mentioned in these documents are said to have originated in the time of Cheops, 3700 B.C., and all of them show that medicine had been heretofore and was then essentially a magic art, and the physician more or less a priest. Even in early times drugs were plentiful, and we find that the ancient Egyptians were acquainted with numerous remedies, such as opium, castor-oil, peppermint, yeast, turpentine, magnesia, iron and soda. The Egyptians made pills, too, and plasters, powders, and ointments. The custom of embalming, which was a religious ritual based on religious beliefs, was a valuable anatomical training, for in the process of embalming, the heart and the viscera were removed and put into jars. In spite of such practice, however, the anatomical knowledge of the Egyptians was very imperfect.

In the Western world medicine began in Greece. We meet with fragments of contemporary medicine in the earliest Greek literature. When we come to the period of Greek philosophy we find that charms and incantations, and magic of all kinds, are beginning to play a less important part in medicine. The king of the physicians of the period of Greek philosophy was Hippocrates, usually called the Father of Medicine. The Greek mind was emerging from the rosy mist of myth and superstition, and in the dawnlight of reason was learning to distinguish between fact and fiction. In practice, Hippocrates relied more on general measures than on drugs. He poulticed, bled, dieted; he gave purgatives and diuretics as required; he prescribed baths and change of air. A special feature of

the Hippocratic system of medicine was its study of symptoms with a view to diagnosis and prognosis.

Galen, 131-201 A.D., a follower of the Hippocratic school, was the most skilled practitioner of his time, but has left on record only miraculous cures. He was the founder of experimental medicine; was first to describe the cranial nerves and sympathetic system.

Vesalius, a Belgian anatomist of the sixteenth century, may be counted the originator of modern anatomy and the layer of the foundations of modern medicine.

The founder of modern scientific surgery was Ambrose Paré, 1510-1590. He established the principles of surgical cleanliness, introduced massage, and many instruments.

The foundations of modern pathological anatomy were laid by Morgagni, 1682-1771. He performed the first autopsy.

Edward Jenner, an English physician, 1749-1823, experimented for many years with vaccine lymph as a specific for smallpox.

Louis Pasteur, 1822-1895, the French chemist, discovered the part played by microscopic forms of life in the process of fermentation and in the development of infectious diseases.

Surgery was completely revolutionised by the English surgeon, Joseph Lister, 1827-1912, by making use of the principles of asepsis and antiseptis.

The greatest clinical teacher of his time was Sir Wm. Osler, 1849-1919; a Canadian professor of medicine and pathologist. His influence on clinical and medical school education did more, probably, to elevate and advance the standard of medicine and, indirectly, hospital organisation, hence nursing, on this continent than any other single person.

It was religion which first induced women in the earlier centuries to take up the care of the sick as a charitable duty.

One of the earliest Christian hospitals of which we have record was one founded in Rome by Fabiola, a patrician Roman lady, in 380 A.D. Her life and fortune were devoted to the care of the sick poor. The deacons of the church attended on the poor until the fourth century of the Christian era. The hospitals were managed by the clergy. There was greater Christian charity carried on, especially in the country regions, for the people had the stranger to care for, and the sense of human duty was more binding than in the modern world. The members of nursing sisterhoods were at first not bound by vows and did not wear a distinctive dress. The religious habits worn by these women date from the thirteenth century.

Since the time of the apostles, pilgrimages were made to the Holy Land. Many hospitals were needed along the way to care for those who made these dangerous journeys, and this need was the means whereby a great number of hospitals were established.

We find many principles of modern sanitation mentioned in the Jewish law of Bible times, provision being made for food inspection, notifying certain authorities of communicable disease, disinfection, and quarantine.

The origin of the monastic system, which arose in the East, is undetermined, but at a very early date recluses shut themselves out from the world and lived in solitary retirement and devoted themselves to prayer, religious exercises and works of charity. The deserts of Egypt were thronged with recluses. Times were lawless and the monastery gave shelter under protection of the Church. Decline came in the system in the form of a protest against the formalism and self-repression which crept into the monastic life. Then we find secular nursing orders developing.

These orders, founded in 1296, have carried on from that time until the present, in the Florentine cities.

They were highly distinguished for their splendid works and broad professional ideas. Many women who endowed the hospitals gave their lives to service in caring for the sick.

The period from the later part of the seventeenth century to almost the middle of the nineteenth century is a dark one in the annals of nursing. The care of the sick was left largely in the hands of the ignorant; even among the various sisterhoods progress came to a standstill, and hospital conditions were unspeakable.

Toward the end of the dark period of nursing, in 1836, an institution for the instruction of deaconesses, under the direction of Pastor Fliedner and his wife, was founded at Kaiserworth, Germany. It was with this undertaking that modern nursing may be said to have begun.

One of the most unique characters in the history of nursing was an English woman, Florence Nightingale, born May 12th, 1820. She was an eminent sanitarian and statistician, with a deep interest in hygiene and the conservation of health. At the outbreak of the Crimean War, 1854, Miss Nightingale, with her staff of forty nurses, went to the East to take charge of the distressed, neglected, sick and wounded British soldiers. They found conditions in a most pitiable state of neglect—no sewage system, no laundry or supplies of any kind; and the death rate had reached fifty per cent. Miss Nightingale's greatest achievement was that she practically overthrew the whole method of managing the British army sick and wounded. Aside from nursing service, she installed sanitary engineering, brought in supplies and equipment. In gratitude to Miss Nightingale, the British nation presented her with a substantial sum of money, which she used to found a nurses' training school in St. Thomas's Hospital, 1860, under the superintendency of Mrs. Wardroper.

Dr. Anna Hamilton, of French birth, 1864, became the pioneer of the Nightingale system in France.

Linda Richards (1842-1930), after distinguishing herself by her work in Boston, founded a mission training school in Japan. On her return she carried on a training school and reformation in hospitals for the insane. The New York Hospital (1771) was first to make the attempt to instruct its nurses. In 1861, the Women's Hospital, Pennsylvania, opened a school for nurses.

The Mack Training School of the General and Marine Hospital, St. Catharines, Ontario, was opened in 1865, and in 1873 it was organised on the Nightingale principles—matron of nurses' home and four graduate nurses. The training school of the Toronto General Hospital was opened successfully in 1881, that of the Winnipeg General Hospital in 1887, while in 1890 a school was established in the Montreal General Hospital.

As we have traced down through the ages, we find as each period unfolds it has revealed to us some wondrous revelation of the arts of medicine and nursing, and we know not what hidden treasures the future holds in store for us.

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[This essay was written by a member of the preliminary class, 1931, School of Nursing, The Galt Hospital, Galt, Ontario. In submitting this essay for approval for publication, the Superintendent of the Hospital explained that recently, for various reasons, she had changed her method in teaching History of Nursing. The plan followed at present is: The headings of the subject matter are given to the class, who secure information which is later checked in class. When the subject is covered each probationer is asked to write an essay on the History of Nursing, covering the ground she has found most interesting or instructive. The only stipulation enforced is that the student's own language must be used, not mere copying from any source of material.—Editor.]

Relationship of Doctor, Nurse and Patient in Hospital

By E. H. McHARG, Operating Room Supervisor, Jeffrey Hale's Hospital, Quebec, Que.

In any hospital, large or small, there are three groups: the doctors, the nurses and the patients. On the first rests the responsibility of directing the treatment of patients. In the hands of the second group rests the care of patients and their general well-being in hospital, often also, in their hands is the success or failure of the treatments given. The third group is the group for whom hospitals and their staffs exist. It is to care for and help suffering humanity that hospitals, expensively equipped and staffed by specialists, have come into being.

The equipment of a hospital and the care and skill with which that equipment is used are important. The general attitude toward patients and the co-operation of doctors and nurses are of great consideration in carrying on the work of a hospital harmoniously and successfully. Many patients have been cured almost entirely by the "bedside manner" of doctor and nurse, while the psychological reactions of patients to two groups such as doctors and nurses, must necessarily be of great importance.

The first contact with the patient entering hospital is made by the nurse receiving him. From this moment on the attitudes and psychological reactions of the patient become of supreme significance. To the majority of patients entering a hospital is a venture into the unknown, taken only under stress of circumstances and usually with many misgivings and some temerity. Frequently, the patient's first impressions are lasting, and here it is necessary that the nurse receiving patients should show consideration and understanding sympathy. True, a nurse may have experienced a very busy day and then shortly before going off duty have to admit a patient. The patient may be nervous and somewhat agitated, while the nurse is on "edge". Nevertheless, the nurse must make the experience

as easy as possible for the patient so that his entrance may be a positive first step toward eventual recovery, and not a negative experience.

Once in hospital the attitude of both doctors and nurses influences the progress of the patient toward recovery. The daily contact of nurses with the patient should aid in recovery by increasing the confidence of the patient in the nurse and in her ability to further his progress toward eventual recovery.

The manner of the doctor when visiting the patient is also of great importance. In a large measure the patient looks to him for the treatment which will bring restored health. We are all familiar with the doctor who, in modern parlance, "breezes in" on a patient and in a hearty way assures him that recovery is now only a matter of days, and then breezes out again; something after the manner of a football coach giving his team a "pep talk" before a big game. Sometimes that is really the best treatment of all, but when used exclusively it is liable, often, to be worse than useless.

The opposite type of doctor is perhaps more common and also more of a negative quantity in a patient's recovery. On entering a patient's room he assumes his most funereal manner and after carefully examining the chart consoles him with the reassurance that if the improvement continues he may be allowed full diet next week. Probably before the doctor's visit the patient had visions much rosier than that, but after the visit he is not sure whether he will have full diet next week or whether by that time he will be feeding on the ambrosia of the gods of eternity. All of which produces a state of mind unfavourable to rapid recovery. Neither of these types further the welfare of the patient to the fullest extent. Many doctors, however, exhibit a great understanding, not only of medical

science, which is the foundation of their work, but also of the reactions and mental attitudes of those who come under their care.

Nurses fall into similar classes to the above. Some nurses approach the patient in a nervous and excited manner which jars the patient's nerves, while others, in their efforts to pep up the patient, exhaust him. The nurse, however, who displays easy assurance in her care of a patient and interprets his needs without fuss or annoyance is much to be preferred to either and can do much to help forward the patient's recovery.

Where surgical cases are concerned, consideration of the patient's mental state and general condition is of even greater importance than in ordinary medical cases. Probably the thought of a fatal ending to the operation enters the mind of most such patients, and in actual fact such an ending is not unknown even where the operation is successful. Therefore, it is paramount that the patient be given every assurance possible before the operation. These cases are in a state of great mental agitation and especially when operations are performed under regional or local anaesthetic it is necessary to talk to and encourage the patient both before and during the operation.

The effect on the patient of the surroundings in the operating room and of all evidences of preparation for an operation are likely to be disturbing, and it is necessary for both doctors and nurses to co-operate in lessening the adverse reactions of the patient to the atmosphere of the theatre.

Nurses who scrub for operations exercise all the care possible in preparing a sterile field and the instruments necessary, but cannot anticipate demands of doctors outside of the requirements of the operation as posted. It is necessary that the utmost co-operation be shown on the part of doctors. It is manifestly impossible for a nurse who is taking an operation to know before the operation begins that a doctor after commencing an appendectomy will decide to do a cholecystectomy or a gastroentero-

stomy. When such a situation arises the doctor is likely to expect the immediate production of instruments outside of those required for the original operation, a thing which may or may not always be possible. Nevertheless, doctors usually expect such feats to be performed and are likely to register an adverse reaction if they are not; such an attitude is liable to reduce the efficiency of a nurse. When a major operation is being performed the nurse taking the case is under tension and it is the duty of the doctors to be agreeable and to co-operate with the nurse to the fullest extent in order that everything may go forward smoothly and harmously. For discord or friction to be developed at this time must have an unfavourable effect on all present.

Doctors are not always to blame for much of the unnecessary discord and friction in the operating room during an operation. The royal and ancient order of "passing the buck," to use a colloquialism, is by no means unknown to some nurses—one of the nurses who is responsible for instruments or other equipment is called on for something at an important moment, but cannot produce it, in quite a number of cases she blames the absence of it on some other nurse present who is not in any way responsible, thus a great deal of unnecessary friction is produced. Such friction and consequent loss of time is likely to have adverse effect on the surgeon. All of which creates an atmosphere the reverse of favourable for smooth and expeditious work; this shows the need for the maximum amount of understanding between doctors and nurses in carrying on the work in hand, and also the need for a greater appreciation, on the part of many doctors, of the work done by the nurses. With these should go the fullest consideration on the part of both for the comfort and welfare of the patients under their care, either in medical or surgical cases. Thus the atmosphere of a hospital may be improved and the work carried on in a more congenial and efficient manner than is sometimes the case.

The Saint John General Hospital

An event of great interest to the people of Saint John in general and especially to the nursing and medical professions occurred on October 21st, 1931, when the new Saint John General Hospital opened its doors for the reception of patients. For many years the need for increased accommodation had been urgently felt at the General Public Hospital. In 1929 Dr. Walsh, hospital consultant of the American College of Surgeons, was asked to come to Saint John and make a survey of hospital conditions. As the result of his investigations the old building which had been erected in 1862 was demolished and in its place there stands a modern, up-to-date hospital. The new structure, of stone and brick, stands ten stories high, on the hilltop of the old hospital site, and can be seen from practically every point in the city and for miles around.

In the basement are: large central linen room, sewing room, store rooms, mattress sterilising room, etc. On the ground floor west wing are the out-patients' department, with a large waiting room; social service department; casualty operating room, dental clinic and several examining and dressing rooms. In the centre of this floor is the main kitchen, with special diet kitchen adjoining, and in the east wing are the dining rooms for the staff and student nurses. A large cafeteria serves the student nurses.

All special diets are served directly from the special diet kitchen and food for general diets is sent to the floors in electrically heated containers and distributed from serving rooms on each floor. All the equipment in the kitchens is electrical. Adjoining the main kitchen are refrigerators, cold storage, vegetable preparation, butcher shop, bake shop and help's dining rooms.

On the main floor are the x-rays, physiotherapy and pathological departments, in addition to the general and executive offices, staff room, board room and record room, also in-

ternes' quarters and accommodation for thirty patients.

The third floor is the main section for ward patients, having one hundred and ten beds. The wards are all small, the majority having only four or five beds, the largest nine beds. Between each two wards is found a toilet and wash basin, which facilitates the work of the nurses to a great extent. A utility room with built-in cabinets is found in each wing, and the supervisor's station is in the centre, where she can command a view of the whole floor. A solarium is provided at either end for the use of convalescent patients. The fourth and fifth floors are for the use of private and semi-private patients, each having accommodation for thirty-eight patients. The sixth floor is for obstetrical patients. This is an entirely new department as the old hospital had no provision for maternity cases. A large, airy nursery is in the centre, the east wing has twenty-eight beds for ward cases, and the west fourteen private rooms. Three case rooms, labour rooms, preparation room, baby examining room and two post-natal rooms are available for the obstetrical department.

On the seventh floor is the operating theatre, case rooms, and a large central work room. In this room all the sterilizing for the whole hospital is done and the supervisors send in requisitions twice daily for supplies. The operating suite comprises three major and three minor operating rooms, urological and orthopaedic rooms. Between the two latter is an x-rays machine.

The eighth floor is given up to the paediatric service. In the centre is an observation ward of six beds, with utility and service rooms. Here the small patients are kept from six to eight days. The wards are cubicle style, with glass partitions, and at either end of the floor is a bright, sunny playroom, opening out on to the roof, where the little ones can get the full benefit of the sun, high up above the smoke and dust of the city.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

Educational Problems of the Small Hospital

By GERTRUDE JOHNSON, Superintendent, General Hospital, Neepawa, Man.

With the release of the Weir Report on the Survey of Nursing Education in Canada, there will be further discussion of the question whether or not the small hospital school of nursing can produce properly trained nurses. Much of previous discussion of this question has been unfavourable to the small hospital; we have failed to discriminate between essentials and non-essentials in dealing with such problems and also have confused quantity with quality.

To furnish proper instruction in nursing a school must have:

(1) A sufficient number and variety of cases to give all students reasonably good experience in medicine, surgery, obstetrics and pædiatrics.

(2) Sufficient up-to-date equipment for doctors and nurses to carry out modern procedures in the care of patients.

(3) Competent lecturers and instructors to assure the students adequate instruction.

(4) Competent supervision. Deficiencies can usually be met by affiliations, and although these are often difficult to arrange on account of class-work, many schools maintain them successfully.

The greatest difficulty is encountered in the matter of instruction, and here we find a strange theory—that one instructor is enough to teach all subjects, even when the curriculum requirements are stated in hours. Usually six or seven hours are spent daily in the classroom; if the instructor is to arrange her programme, prepare her lessons, correct papers and note-books, she will be devoting eleven or twelve hours daily to her work, much longer

than is required from any other teacher.

Yet there are individuals who believe that one nurse can do all this and in addition carry the multitudinous duties of superintendent of the hospital and school of nursing, keep an elaborate system of records, do follow-up work on the wards—just because the hospital is a small one. The superintendency of even a small hospital and school is a full-time job, and any nurse who carries that responsibility has only a small margin of her time left to think about instruction, let alone doing it.

Probably the hardest stumbling block is that of convincing the members of the board that it takes just as much time to teach a small class as a large one and that one person cannot possibly be in two places at the same time.

Doctors are very loath to give up their time to lecturing; much time is required in educating them to become interested in Nursing Education; unless one has patience, tact and diplomacy it is difficult to anticipate encouraging results, and the whole matter may inevitably resolve itself into never-ending strife and source of worry. Hearty interest and co-operation on the part of the medical men in teaching according to the outlined curriculum is a most important asset of the school. The superintendent of a school of nursing once informed me that it was impossible to get the doctors to do very much lecturing: two, or perhaps three, rather ungraciously gave up a few hours of their time to nursing education, much of which seemed to lack even the

fundamentals of real teaching. There are very few student nurses who fail to recognise bluff, and the situation is apt to become a difficult one; however, to accept it in the light of the impossible is a grievous mistake. Nothing is impossible of accomplishment when one has acquired patience and diplomacy.

Competent instruction and supervision mean money, and funds for these are often quite inadequate. This can be overcome by an interested hospital board, with the help of a

community sufficiently proud of its hospital to give the necessary backing, with few complaints.

The size of the hospital maintaining a school of nursing is only part of the story. Quantity is a poor standard by which to measure anything, and the quality of the training offered the students should be the determining factor in whether or not certain hospitals are fit to conduct schools of nursing; therefore, let us resolve to admit only the best material and to concentrate on quality.

An Interesting Refresher Course

By GRACE M. FAIRLEY, Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

A Refresher Course for Institutional Nurses was recently arranged by the Graduate Nurses Association of British Columbia and its success was probably due to the very practical form it took. The need for better ward teaching and the responsibility of the head nurse was stressed through all the sessions.

Dr. George Weir gave a series of four lectures on teaching problems and with his wealth of information about the nursing profession, the problems he discussed and the recommendations made were most helpful. The various methods of teaching, types of examinations and their values were among the points under discussion.

Dr. A. K. Haywood gave four lectures on hospital administration and briefly but concisely took as his main topics:

- (1) General administrative problems under sub-headings,
 - (a) The admitting office,
 - (b) The information desk,
 - (c) The telephone exchange,
 - (d) Publicity.
- (2)
 - (a) The essentials in a building programme to meet modern hospital demands,
 - (b) The cost of maintaining an adequately equipped hospital,

- (c) The hospital's responsibility as an educative centre in the community.

- (3) Food and food service.

- (4) Laundry and laundry equipment.

These lectures were most instructive and helpful to members from large and small hospitals alike. They covered many of the problems found in all hospitals.

The nursing sessions, of which there were six, were conducted by Mrs. Wayland (nee Mary Marvin) of Columbia University, and were entirely based on ward management and ward teaching from the head nurse's standpoint. Her programme was carefully planned and very well presented. Model classes were given by members of the association which included a bedside clinic to a group of students, and a nursing class following a medical lecture. There were also contributions and demonstrations by the Victorian Order Supervisor, showing the type of instruction given to students taking the V.O.N. affiliation, a supervisor of a paediatric department outlining how the student nurse's course is planned and how and when clinics are given. A supervisor of an obstetrical unit also contributed to the programme by describing the teaching points to

be covered in a special department.

The "Case Assignment Method" as a means of stimulating the interest of the student, and in developing powers of observation and responsibility, resulting in better bedside nursing, was brought out at all sessions. Nursing a patient as a whole rather than carrying out specified duties for a number of patients appeared to give the most satisfactory results. The pros and cons of both "Case Assignment Method" and "Functional Method" were very freely discussed.

Because of the very practical (as

well as inspirational) form of this Refresher Course and the great benefit received by all members young and old, it was felt worthy of publication, so that any other associations contemplating such a course might benefit by it.

The details of Mrs. Wayland's sessions are appended. Her dignity and forcefulness as a practical teacher and her first-hand knowledge of the head nurse's problems, weaknesses, assets and what constitutes an ideal head nurse were all presented in a way that made for the great success of the course.

WARD MANAGEMENT AND WARD TEACHING

Tuesday, February 23.—2 one-hour periods:

1. Introduction to the programme on ward teaching: Mary M. Wayland.
2. The educational assets of a department or ward: Mary M. Wayland.

References:

1. 33rd Annual Report National League of Nursing Education, 1927, pp. 132-135.
2. 34th Annual Report National League of Nursing Education, 1928, pp. 145-154.
3. 35th Annual Report National League of Nursing Education, 1929, pp. 106-110.
4. A Curriculum of Schools of Nursing, pp. 37-41 (1929).
5. The Canadian Nurse Magazine, Dec., 1925, p. 639, Nursing Service in Hospital Wards: Fraser.
6. The Canadian Nurse Magazine, Dec., 1926, p. 634, Ward Administration: The Head Nurse.
7. The Canadian Nurse Magazine, Oct., 1930, p. 540: The Head Nurse as Teacher.
8. American Journal of Nursing, vol. 31 (1931), p. 541, Ward Content: Sewell.
9. American Journal of Nursing, vol. 31, p. 1429, Clinical Experience: Ruth Ingram.
10. American Journal of Nursing, vol. 30, p. 1053, Supervision of Clinical Instruction: Marvin.
11. An Experiment in the Correlation of Theory and Ward Experience in Surgical and Medical Nursing: Smith, A. J. N., vol. 28, p. 1135.

Wednesday, February 24.—4 one-hour periods:

1. The case method vs. the functional method in nursing: Mary M. Wayland. (Discussion from the floor urged.)
2. Principles underlying the assignment of ward experience to student nurses:
 - (a) Assignment of nursing responsibilities to students in a paediatric department; Miss Bertha Marsden, Supervisor, Infants' Hospital, Vancouver.
 - (b) Assignment of nursing responsibilities to students in an obstetrical division; Miss Oliver, Supervisor, Maternity Department Provincial Royal Jubilee Hospital, Victoria.
 - (c) Further discussion: Mary M. Wayland.

References:

1. Teaching Nursing by the Application of the Case Study Method: Effie Taylor, *Modern Hospital*, Dec., 1926, p. 112.
2. Methods of Rotating Students: Bacon, *American Journal of Nursing*, vol. 31, p. 1419.
3. The Case Study Method of Nursing: Ham, *Pacific Coast Journal of Nursing*, Feb., 1932, p. 84.
4. What Wisely Planned Assignments Mean to Student Nurses: *Modern Hospital*, June, 1930, p. 109.
5. Ward Study Units in Medical Nursing (Elementary and Advanced): Florence K. Wilson, Lippincott.
6. Case Report, Students in Unsegregated Services: *American Journal of Nursing*, Dec., 1930, p. 1556.
7. A Case Study Method of Teaching Nursing: Effie J. Taylor, *The Public Health Nurse*, Feb., 1925.
3. Methods of Teaching in the Ward.
Supervising as a method of teaching.
Supervising the nursing and nurses in the field of public health.
Discussion: Miss Duffield, Supervisor, Victorian Order of Nurses, Vancouver.
Further discussion: Mary M. Wayland.
4. The Clinical Method of Teaching: Mary M. Wayland.
Demonstration of a Nursing Clinic, Miss Jean Davidson, Instructor, St. Paul's Hospital, Vancouver.

References:

1. Supervision: Burton, A.J.N., Aug., 1930 (vol. 30), p. 1045.
2. Changing Conceptions of Supervision: Grace Day, *Modern Hospital*, May, 1925.
3. Principles of Supervision: Wayland, *Pacific Coast Journal of Nursing*, Feb. 1932, p. 86.
4. A Supervisor's Plan for Running Her Department, *Modern Hospital*, Sept., 1930, p. 104.
5. Clinical Methods of Teaching in Schools of Nursing: Scott, *The Canadian Nurse Magazine*, April, 1927, p. 191.
6. *Equinimitas* and Other Oddresses: Osler (contains pertinent references on bedside teaching).
7. Medical Education, *The Clinics*: Abraham Flexner, ch. 10.
8. Supervision in Schools of Nursing: Wolf, *The Canadian Nurse Magazine*, June, 1927, p. 304.
9. Ward Teaching: Batson and Flanagan, *The Canadian Nurse Magazine*, April, 1930, p. 186.
10. The Correlation of Theory and Practice in a Programme of Nursing Education: Koch, *Trained Nurse and Hospital Review*, Oct., 1931, p. 496.
11. Staff Conference and Conference Leadership: Sorenson, A. J. N., Sept., 1930, p. 1176.
12. The Morning Conference, A. J. N., Sept., p. 1053.
13. Staff Conference from the Standpoint of the Graduate in Charge of a Ward: Jackson, *The Canadian Nurse Magazine*, July, 1925, p. 356.

Thursday, February 25.—4 one-hour periods:

1. Ward Teaching, continued. The Case Study Method in Nursing, continued: Mary M. Wayland:
 - (a) What is the nature of a nursing case study?
 - (b) Is the case study restricted to the nursing school?
 - (c) What is a good method of introducing this type of teaching into the nursing school?
 - (d) What are our problems in relation to the case study method in nursing?
 - (e) Purposes and value of this method in nursing?

References:

1. The Case Study Method Applied to Nursing. An outline of a course in case study printed in the book—*A Curriculum for Schools of Nursing*.

2. Student's Handbook on Nursing Case Studies: Deborah MacLurg Jensen.
3. Teaching Nursing by the Application of the Case Study Method: Taylor and Rottman, Modern Hospital, Dec., 1926, p. 112.
4. Principles of Teaching in Schools of Nursing: Sister John Gabriel, ch. 2 and ch. 6.
5. Case Study: Munson, A. J. N., vol. 30, pp. 304-306.
6. Case Study Method: Kelly, Trained Nurse and Hospital Review, Jan., 1927.
7. The Case Study (in P.H.N.), A. J. N.: Buell, April, 1930.
8. Case Study as a Method of Ward Teaching: Graves, A. J. N., Jan., 1930.
9. Principles of Public Health Nursing in the Under-Graduate Course: Grant, 31st Annual Report of the N.L.N.E., 1925, pp. 133-138; 31st Annual Report of the N.L.N.E., 1925, pp. 124-132.
10. 35th Annual Report of the National League of Nursing Education, 1929, pp. 165-173.
11. Problems in the Use of the Case Study Method: Petry, A. J. N., Feb., 1931.
12. What's the Matter with Case Study Methods?: Cowan, Trained Nurse and Hospital Review, June, July, Aug., 1930.
13. Refer to case studies printed in:
 - (a) The Canadian Nurse.
 - (b) The American Journal of Nursing.
 - (c) The Pacific Coast Journal of Nursing.
 - (d) The Trained Nurse and Hospital Review.

Thursday Afternoon:

1. Summaries of the work in the ward or department: Mary M. Wayland. (Discussion from the floor urged.)
2. (a) Evaluation of the student's work.
(b) Evaluation of the head nurse's work: Mary M. Wayland.

References:

1. Records, Their values: Mohr, The Canadian Nurse Magazine, Feb., 1931, p. 88.
2. Records in Schools of Nursing: Gage, American Journal of Nursing, vol. 29, p. 567.
3. Sellev Ward Administration: Sellev.
4. The Case Study Method of Nursing: Ham, The Pacific Coast Journal of Nursing, Feb., 1932, see p. 85 for record.
5. A Compilation of Students' Records Required for the Course in Medical Nursing. Published by the Nursing Staff at the Yale School of Nursing, 1931.
6. Practical Exercises for Learning to Rate Teaching Skill and Methods: Leo. J. Brueskner, University of Minnesota. Published 1929.
7. Samples of Teacher Self-Rating Cards, U.S. Bureau of Administration; City School Leaflet No. 18, Feb., 1925.
8. The Department of Superintendence Eighth Year Book; ch. 6 and 7, Measuring the Supervision. Published by the Department of Superintendence of the National Education Association, Wash., D.C., Feb., 1930.

Friday Afternoon, February 26.—2 one-hour periods:

1. Further methods of correlating class room teaching and ward practice: Teaching the classes following the doctor's lectures: Mary M. Wayland.
2. Demonstration of the teaching of a class "The Nursing Care of Typhoid:" Teacher: Miss Cooke. Instructor, Provincial Royal Jubilee Hospital, Victoria. Students: Vancouver General Hospital.

References:

1. Teaching the Classes Following the Physician's Lecture: Lelin Townsend, A. J. N., vol. 31, p. 1183.
2. Teaching and Supervision of Surgical Nursing: Traey, 32nd Annual Report, N.L.N.E., 1926, p. 121.
3. Some Suggestions for the Planning of Lessons: Helen W. Munson, A. J. N., vol. 30, p. 1183.
4. A Curriculum of Schools of Nursing. Published by the National League of Nursing Education, 450, 7th Ave., New York City. See outline for the course in medical nursing with references, p. 119.
5. A Text Book of Medical Diseases for Nurses, Including Nursing Care: by Arthur Stevens, A.M., M.D., and Florence Ambler, R.N., B.S.
6. Articles on nursing care in medical, surgical, psychiatric, paediatric, etc., in various journals of nursing, especially the A. J. N.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,

Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

What Type of Assurance Should a Nurse Engaged in Private Practice Purchase ?

To give a definite answer to this question is as impossible as to attempt to give a definite answer to "What medicine or treatment should a nurse engaged in private practice be given?"

There was a time when a particular type of assurance policy was sold as a cure for the financial ills of all and sundry in much the same manner as certain patent medicines were supposed to cure every physical ailment. Today we consult the trained physician, who diagnoses our trouble before prescribing medicine. Likewise, the trained life assurance man will carefully analyse his prospect's need before recommending any particular type of assurance contract. The need of individual nurses may vary considerably and, consequently, a different type of "treatment" should be given.

There are, however, two great hazards with which life assurance is concerned—the problem of *early death* and the problem of *old age*.

Without being dogmatic, it is safe to say that every nurse needs a death benefit of one or two thousand dollars, enough to cover her current liabilities and hospital, medical and undertaking fees in the event of her death. In addition to that, she should have a contract which will provide enough money at age, say, fifty-five or sixty, to purchase an adequate pension for the rest of her life.

Her "insurance policy" of one or two thousand dollars, if on the endowment at age 55 plan, would fit into this programme admirably, and a pension bond contract, maturing at age 55, supplementing the cash in her life assurance policy, would provide the necessary funds to purchase the pension above referred to.

By this method, the maximum results can be secured for the minimum outlay, but it must be understood that the case of each individual should be considered carefully and her most urgent needs discovered before any definite recommendation could be intelligently made.

Copies of the Report of the Survey of Nursing Education in Canada can be ordered from the Secretary of each provincial Association of Nurses; from the National Office, 511 Boyd Building, Winnipeg, Man., and from the University of Toronto Press, Toronto, Ont. The price is \$2.00 per copy, or in lots of ten \$1.75 each. It is suggested that all registered nurses obtain copies from their provincial secretary.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.

MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

In the Island Province

By MONA G. WILSON, Director, Public Health Nursing, Prince Edward Island.

Down in that island by the sea, Canada's smallest province, Prince Edward Island, commonly known by the enchanting title—"The Garden of the Gulf," the entire public health nursing field has been, until recently, under the direction of the Canadian Red Cross Society. This is perhaps a unique situation for provincial health work. But in the old and conservative eastern provinces, where communities are not easily weaned from the ways of their forefathers, the soil for new endeavour is sometimes ploughed with difficulty. However, away back in 1921 the Red Cross Society, as its peace-time programme, inaugurated public health nursing in the Island. Prior to this there had been no organised effort along health lines. Naturally there was a good deal of opposition to the launching of this new scheme. In fact, it was said by some that this work could not be accomplished, by others that "People wouldn't stand nurses going into their homes and telling them what to do for their children." The unchallenged reputation of the Red Cross for constructive health work won the day, and the new work was finally commenced with one public health nurse and the schools as a centre of activity.

Progress was slow and discouraging at first. Means were limited. Public interest and support were difficult to arouse, and the hundreds of practical difficulties which beset the pioneer were intensified by the general apathy towards health problems. To the determined efforts of one nurse, backed by the Department of Education, the Red Cross owes the success of those early days. Subse-

quently two and three nurses, and finally four were appointed, as the work grew to undreamed of proportions. Their constant contacts with the school children, teachers, parents and public groups, the valuable information, advice and help they were able to give, won the confidence of everyone, and after ten and one-half years of service to every district in the province the Red Cross was looked to for guidance in all health matters.

During these years the services given were varied and extensive. All the four hundred and seventy-six public schools in the province, and one private school received periodic inspections. The children were examined and their homes visited. The home visiting was particularly valuable, as it brought the nurses into touch with the pre-school children, infants and expectant mothers, thus strengthening the health campaign in the schools by securing co-operation at home. Dental and tonsil clinics were held and instruction given in home nursing and first aid to adult and junior groups. Lectures were also given on health topics to teachers in training. In addition to this health education work in the schools, two health centres were maintained by the Red Cross. These were visited by hundreds of people each year, seeking information and bringing their children to be weighed. As a result health exhibits at fairs and other public gatherings drew crowds. Thousands of pieces of health literature were distributed, and the work of the Red Cross went forward in bounds.

Co-operating with the Canadian Tuberculosis Association and the Maritime Tuberculosis Educational

Committee, chest clinics were held twice a year throughout the province, and the tuberculosis home visiting was also undertaken by the Red Cross Public Health nurses. When in 1929, for the first time in the history of the province, a full-time provincial health officer was appointed, who was also a chest specialist, a weekly clinic was held at the Red Cross office in Charlottetown, in addition to these rural clinics. At this time the province-wide vaccination campaign was also managed by the Red Cross Society, when 6,217 children were vaccinated, also a diphtheria immunising campaign, during which 9,320 children were inoculated.

The work among the crippled children of the Island has been particularly gratifying. Here, of course, one has the rare satisfaction of seeing results, and the new joy of living, to which every child is entitled, and which has only been gained for these unfortunate kiddies through the work of our crippled children's clinics, is an enduring reward. Clinics for crippled children are held twice a year and are attended by a visiting orthopædic specialist. Many of the brilliant operations performed at these clinics seemed little short of miracles to the wee cripples and their families. The good news of cure and partial cure was soon spread, and gradually the early antagonism disappeared. Each year more and more handicapped children receive the benefits of these clinics. Home follow-up work is, of course, done. A corrective clinic under a masseuse is maintained, and educational work is carried on in the homes of those cripples unable to attend school. It is difficult to realise what educational work means to these crippled children, formerly shoved aside. Perhaps a corner by the kitchen stove represented the sum total of their favours in life. Now, at the instigation of the Red Cross, they receive instruction which has opened up whole avenues of "sweetness and light."

A tremendous amount of practical health education is accomplished in the province through the Junior Red Cross. This organisation has grown until it is now organised in fifty-five per cent. of the class rooms of the province, and fifty per cent. of the school children are Junior Red Cross members. Operations, apparatus, eyeglasses, etc., for handicapped children are provided from the Junior Red Cross fund. The children are justly proud of what they are able to do for their less fortunate little companions. But best of all, through the Junior Red Cross the children carry the "health game" into their homes and arouse an interest in health work, which the nurses could not begin to accomplish themselves.

In 1924 the Provincial Government, realising the value of the Red Cross Public Health Nursing Service to the people of the province, demonstrated its appreciation by giving financial assistance. Later the Canadian Tuberculosis Association also gave supplementary funds.

On July 1, 1931, the Society reached a happy consummation of its public health effort and splendid record of achievement. The result of its work, and that of the Canadian Tuberculosis Association and Canadian Life Insurance Associations culminated in the reorganisation of health services under a newly established Government Department of Health. This is now composed of a Minister of Health, a chief health officer and assistant health officer, five public health nurses, two sanitary inspectors and a laboratory technician. The chief health officer is also superintendent of the recently opened Provincial Sanatorium where the offices of the health department are located.

The Red Cross Society, after doing the pioneer work and laying a sound foundation for future public health development, is "Still Serving" in Junior Red Cross and remedial work for handicapped children in the Island Province.

United States' Nurses Meet in Texas

There is one word which pictures fully and accurately the programme that is being built for the biennial convention of the three national nursing organisations of the United States, to be held in San Antonio, Texas, April 11-15. That word, which describes every programme from the great joint sessions to the smallest round table, is *practical*. There will be a minimum of theorising on the joint programme of the three organisations or on the programme of the American Nurses Association, official organisation of graduate nurses in the United States.

Improved nursing service to the patient at a possible reduction in cost is to be expected when great grading and distribution projects now being carried on are more nearly completed. Just how the nurse, through her organisation, and even individually, may contribute to this most important nursing goal is the idea behind the programme.

For five years, the Committee on the Grading of Nursing Schools has been making a most comprehensive survey of nursing economics and education. Its findings indicate clearly that there is an over-supply of nurses in the private duty field. They indicate that nurses are being graduated now at the rate of between twenty-five thousand and thirty thousand a year, so that nursing is facing the immediate problem of considerable over-supply unless the output is considerably curtailed.

This aspect of the nursing situation will be presented at the coming biennial in two joint sessions of the three organisations. The first of these, to be held on Tuesday, April 12, has as its general topic, "Nursing at the Cross-roads." At this time there will be discussed the implications for nursing in the findings of two five-year studies: (a) the Committee on the Costs of Medical Care, and (b) the Grading Committee.

But it must not be thought that American nursing has merely accepted findings without seeking solutions through experiment. For the past several years in many places throughout the country there have been experiments; for instance, in the use of the graduate nurse in preference to the student for floor duty and the substitution of a graduate staff for a nursing school. There have been experiments in the distribution of nursing service through the registry, a most helpful piece of work having been carried on in this connection through study and organisation in the American Nurses Association.

So now in the convention these positive signs will be reflected in practical discussion at the various sessions. At this Tuesday joint session, for example, following the reports of the findings in these two major studies, there will be discussed significant adjustments in nursing service and partnership with the public.

The following morning this effort to work forward from found facts will be even more conspicuous. The general topic will be, "Next Steps for Nursing"; and various speakers will endeavour to answer the following three questions:

"How shall we select and prepare the undergraduate nurse?"

"How shall we select and prepare the graduate nurse?"

"How shall we distribute nursing service equitably?"

That evening, in a general session, Professor Arthur J. Todd, head of the Department of Sociology, Northwestern University, will discuss in general the present economic situation.

A new feature so important as to be accorded an entire joint session is mental hygiene in nursing. Dr. C. M. Hincks, Director, National Committee for Mental Hygiene, and Effie Taylor, Chairman of the Mental Hygiene Section, A.N.A., will speak.

Practical for the nurse membership at this difficult time in personal and professional economics will be the sessions of the American Nurses Association. Relief and investment will constitute topics for one session, including consideration of the kind of relief that nurses need, the responsibility of the hospital and the nursing agency for its sick nurses, and practices in advising nurses in their investments. A second general A.N.A. session will consider economics and private duty. Salary cuts as related to non-employment of nurses will be considered at this time, as also will

be the way in which the present economic problem is being met through adjustment of fees. Janet M. Geister, R.N., Director at Headquarters, A.N.A., will speak at this meeting on "Suggested Steps in Evading Another 'Depression'."

The National League of Nursing Education and the National Organisation for Public Health Nursing have arranged programmes of a similarly practical nature in the fields of undergraduate education and public health nursing. The latter organisation will observe at this time the twentieth anniversary of its founding.



King's Square,
Saint John, N.B.

(Opposite
Admiral Beatty
Hotel)



Scene in
Prince Edward Island

Canadian Nurses Association Meets in the Maritimes

The prelude to the general meeting of the Canadian Nurses Association in Saint John, New Brunswick, from June 21-25 may well be said to have taken place during the annual meetings of the provincial registered nurses associations in Alberta, British Columbia, Ontario and Saskatchewan. These meetings were held during Easter week, and reports of proceedings are eagerly anticipated, more so than usually, as it is evident from the programmes arranged that all discussion centralised on facts and recommendations submitted in the Survey Report.

The forecast for a record attendance at the general meeting in Saint John becomes increasingly favourable as time for meeting approaches. It seems that if ever members of the Canadian Nurses Association should make an effort to be present at a national gathering, the sixteenth general meeting of the Association is the one demanding consideration and attendance.

The fourth general meeting of the C.N.A. was held in Halifax in 1914; the forthcoming convention is the first held in the Maritimes since then. Our hostesses, the New Brunswick Registered Nurses Association, are leaving nothing undone that will provide for well-planned sessions in comfortably arranged quarters, and we believe that provision will be more than adequate for social relaxation.

A copy of the tentative programme was published in the February number of the *Journal*. The Programme Committee has been most fortunate in their choice of speakers, who will discuss the Survey Report from various angles. Our nurses need no introduction to the Hon. Vincent Massey, who is to be guest speaker on Tuesday evening, June 21st. Mr. Massey will speak from the viewpoint of the public. The following evening, Professor Roy Fraser, of Mount Allison University, will be dinner speaker, when he will discuss the Report from

the scientist's point of view, while on Friday evening, June 25th, Professor F. Clarke, of McGill University, will offer comment from the angle of the educationist, and Dr. Stewart Cameron, chairman of the Joint Study Committee, will present the views of the medical profession. These four addresses form a magnetic attraction for the Saint John meeting.

Release of the Survey Report opens the way to more concrete discussion of nursing problems. Three general sessions will be devoted to three salient aspects of the Report: that is, recommendations regarding the approved Training School, the Cost Analysis of Nursing Education and the Distribution of Nursing Service; as previously mentioned in the February number of the *Journal*, sub-topics relative to each recommendation will be discussed briefly by selected nurses throughout the Dominion. Each of the three sessions will be introduced by a nurse member of the Joint Study Committee, who will summarise discussion and present related resolutions for group consideration. Ample time will be reserved for general discussion. The three sections—Private Duty, Public Health and Nursing Education—are each arranging two sessions when their special business and problems will receive attention.

In the interval between biennial meetings the organisation is directed by the Executive Committee, which meets quarterly. A number of standing and special committees function in relation to the varied activities with which the national organisation is concerned. Three sessions will be allocated to the conduct of business. These include reports and recommendations from committees, sections, provincial associations of registered nurses, and reports of the activities at the National Office.

The Admiral Beatty Hotel is providing excellent accommodation for this general meeting. Nurses are as-

sured every comfort while guests at the hotel. Rates are: Single room, without bath, \$3.00; double room, without bath, \$5.00; single room, with bath, \$4.00, \$4.50, \$5.00; double room, with bath, \$6.00, \$7.00, \$8.00 and \$9.00. Additional persons in room, separate bed, add \$2.00. All rooms have hot and cold water and toilets. Reservation should be made soon to Mr. E. B. Sweeney, Manager, Admiral Beatty Hotel, Saint John, N.B.

Transportation: No arrangement

for special convention rates has been made with the Canadian Passenger Association. The customary Summer Tourist rates offered by the railways and steamship companies are more advantageous to the majority of nurses who will attend the General Meeting in Saint John. In this issue of the *Journal* and also in March, there is published information relative to post-convention tours in the Maritimes. Further information as received will appear in ensuing issues.

Visitors to Prince Edward Island

Nurses planning trips to Prince Edward Island by train or motor, cross Northumberland Strait from Cape Tormentine, New Brunswick, to Borden, P.E.I., on the car ferry—a forty minute crossing. Automobiles can be driven directly on to the deck of the ferry. After docking, a seventeen mile drive or two hours by train, and Summerside is reached—the second largest centre in the province with a population of three thousand. Here nurses should get in touch with Miss Pidgeon, matron, Prince County Hospital and president of the Graduate Nurses Association, who will arrange trips to see the near-by beauty spots and French fishing villages scattered along the coast. Forty miles farther by car across beautiful rolling farm country, or slightly longer by the shore road, or two hours by train, and one arrives at the capital city, Charlottetown. Miss Mona Wilson, Director Public Health Nursing, c/o the Red Cross Society, 59 Grafton Street, will assist nurses in planning trips or will arrange motor drives to the shores (miles of glistening white sand and shining sea that you'll simply adore) or longer drives to the prettiest and most interesting places. The Tourist Association is also at your service.

Trippers who are planning on seeing New Brunswick and Nova Scotia first, and find themselves in the northern part of Nova Scotia,

would find it more convenient to cross to the island on the Hochelaga from Pictou direct to Charlottetown—a matter of four hours.

Members of the Graduate Nurses Association welcome visiting nurses to the island and will be happy to show them around.

Where to stop while in Prince Edward Island:

Charlottetown

Name of Hotel	Rate Per-Day
Canadian National	\$5.50-\$6.50
Queen Hotel	4.00- 4.50
Lennox	3.00
Revere	3.00
Russ	3.00
Cundall Home	2.50

Private homes, recommended rooms, \$1.00 per person per night.

First class restaurants at moderate rates, also recommended homes where meals are served.

Summerside

Clifton	\$3.50-\$4.00
Queen	3.50
Mawley House	3.00

Souris

Cox Hotel	\$3.00
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Montague

Poole Hotel	\$3.00
Commercial	3.00
MacDonald	3.00

Borden

Abegweit	\$3.50 up
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Alberton

Albion Terrace	\$3.00
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Georgetown

Highlands	\$4.00 up
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Seaside Summer Hotels

Beach Grove Inn.....	\$4.00 up
Brackley	3.00
Shaws	3.00
Stanhope Beach Inn.....	3.00 up
Dalvay	4.00 up

Vacation Possibilities in Prince Edward Island

On the eastern marge of Canada, Prince Edward Island lies, crescent-shaped, nestling in the protecting arms of the Gulf of St. Lawrence, and far and wide it is known as a place of beauty and of rest, so that weary men and women come from many directions to sit by its fair waters and roam in its quiet woods and delight their eyes in its strange harmonies of blue sea and vivid green turf and trees and banks of terra cotta.

It justly claims the finest summer climate in the world. Set in the midst of the salt sea it suffers neither extreme of heat or cold, and fog is practically unknown. Nowhere in America can be found its duplicate—inivigorating, restful, refreshing, wonderful warmly tempered salt water bathing all around its thousand miles of coast line. A garden of perfect beauty fanned by cooling breezes from the ocean. Everywhere are verdant fields, prosperous farms and comfortable homes. Arms of the sea cut into the land in all directions, forming landscapes of surpassing loveliness.

The noticeable feature interwoven in the history of Prince Edward Island is the record of the wonderful impression made upon the explorer or traveller of its restful peace and quietness. From the letters of the present-day tourist back to the records of Jacques Cartier in 1534 there is the constant repetition of praise for the beautiful appearance and wonderful climate of this little island by the sea.

Prince Edward Island—called by the French, Isle St. Jean—was one of the first discovered portions of Canada, its authentic history dating from 1534, when Jacques Cartier landed under the impression that he had reached the mainland and in describing it wrote: "All the land

is low and the most beautiful it is possible to see, and full of beautiful trees and meadows. . . . This is a land of the best temperature."

It was for a while in feudal tenure to a French naval officer, Captain Doublet, under whose administration its fisheries were first exploited. After the fall of the great French fortress of Louisburg in 1758, British forces took possession of Prince Edward Island and the great majority of its French colonists were deported.

After cession to England, feudal estates were created, and settlers brought from England, Scotland and Ireland. Many United Empire Loyalists from the United States also found homes in the island colony. The estates were ultimately purchased by the government from the landlords and title made available to the actual settlers.

It was in Charlottetown in 1864 that the famous conference of the statesmen of the British North American colonies took place that led to the formation of the Dominion of Canada, thereby earning for the smallest entering province the unofficial title of "The Cradle of Confederation."

ISLE OF REST

Thou are beloved of sun and sea—
Of silvery night—of glowing noon,
And 'round about thee tenderly
The summer breezes croon.

Thou'rt robed in tranquil loveliness
Of birchen groves and ferny bowers,
Of streams that hold the skies' caress
And fragrant wayside flowers.

No towering mountain heights are thine—
No canyons deep—no forest wild,
And yet thy charms like ancient wine
Are potent seeming mild.

Whose feet have pressed thy velvet strand
Or crossed thy clover-scented lea
May seek for gold in any land
But wearied come to thee.

—L. G. C.

CORRESPONDENCE RE SURVEY REPORT

We are privileged to publish the following letter from Dr. Sinclair Laird, Dean of Macdonald College, Ste. Anne de Bellevue. This letter was addressed to Miss E. F. Upton, Secretary of the Association of Registered Nurses of the Province of Quebec, in acknowledgement of a copy of the Report of the Survey of Nursing Education in Canada:

"Dear Miss Upton:

"I am very much indebted to you for your kindness in sending to me the 'Survey of Nursing Education in Canada' by Professor G. M. Weir.

"This is a historic and authoritative volume on a subject of immense public interest, and I am very grateful indeed to you for being good enough to send me a copy.

"I am presenting this copy to the Library so that the students in the School of Household Science and the staff of the College will have an opportunity of consulting it for information.

"This report is one of the most comprehensive and far-reaching that I have seen, and the nursing profession is to be congratulated on having had such an excellent analysis of its professional position.

Again many thanks,

"Yours faithfully,

(Signed) "SINCLAIR LAIRD, Dean."



Cape Breton Scene



Hedges at
Yarmouth, N.S.

News Notes

ALBERTA

EDMONTON: Friends of Miss S. Christensen will be pleased to learn that she is making satisfactory recovery after her operation.

Mrs. W. Crosby (Miss Bean, Royal Alexandra Hospital), of Wolseley, Sask., was a guest of Miss B. Emerson in March.

LAMONT PUBLIC HOSPITAL: Miss Elva McKee (1924), of Toronto, is spending a few weeks renewing old acquaintance in Alberta. Miss Mary C. McCallum (1922) after a short visit among her friends and relatives in Alberta, has returned to New York, where she will resume her duties in the Doctors Hospital. Mrs. J. Dewey Soper (Carrie Freeman, 1925) has returned from Baffin Island and is residing in Ottawa. Mrs. Chas. Pearce (Edna Patterson, 1926) has returned to Sault Ste. Marie, Mich., after a few months' visit in Alberta. The Christian Nurses Fellowship, begun in Edmonton, March, 1930, is carrying on a successful and inspiring work among student nurses as well as graduates.

MEDICINE HAT: The annual meeting of the Medicine Hat Graduate Nurses Association was held on February 2nd at the Nurses Home, when the officers for the ensuing year were elected. The regular meeting of the Association was held at the home of Mrs. (Dr.) F. W. Gershaw, March 1st. After the business meeting a delightful social hour followed.

BRITISH COLUMBIA

As part of the educational programme of the Graduate Nurses Association of British Columbia for this year, a Refresher Course for Institutional Nurses was planned and held during the week of February 22nd-27th. Although specially arranged for institutional nurses, all nurses were urged to attend, with the result that over two hundred registered, and interest in the programme was maintained from beginning to end. Through the co-operation of the Vancouver General Hospital the lectures were held and luncheon served in the teaching unit at the hospital, luncheon being provided each day by the Vancouver Graduate Nurses Association as their part of the programme. Taking part in the programme were Dr. Weir, Dr. Haywood and Dr. Hill, while Mrs. Mary Marvin Wayland conducted the special sessions on Ward Teaching. Nurses were present from all over the province, and all were emphatic in stating the benefit derived from the course. The annual dinner was held on the 26th, when over two hundred were present and the guest speakers were Mrs. Wayland and Dr. Weir. With the annual meeting so near, the date of the dinner this year was changed to coincide with the Refresher Course.

MANITOBA

BRANDON: The Brandon Graduate Nurses Association held their regular meeting on March 1st. After a short business session Miss Finlayson read a synopsis of Dr. Weir's "Survey of Nursing Education in Canada". Further discussion on the Report will be held at the next meeting. Miss McSorley then introduced the speaker of the evening, Professor Foster, of Brandon College, who gave an interesting address on "The Value of Education". A social hour was enjoyed.

ST. BONIFACE HOSPITAL: The regular monthly meeting of the Nurses Alumnae was held in the Nurses Residence on March 9. After business discussions, a very interesting talk was given by Rev. Sr. Mead, who was the only Canadian representative at a convention in Chicago of the Public Health Nurses and the Central Council of Education. Through the kindness of Rev. Sr. Mead a social hour was then enjoyed.

NEW BRUNSWICK

FREDERICTON: On February 11th, the annual meeting of the Alumnae of Victoria Public Hospital Training School for Nurses was held at "The Palms," when dinner was served to thirty-eight, including Mrs. Woodcock, the superintendent of the hospital, and the members of this year's graduating class. The tables were brightly decorated with spring flowers, and after the toasts the general business was carried out and officers elected for the following year: president, Mrs. J. I. Mavor; first vice-president, Mrs. T. Donovan; second vice-president, Mrs. F. Fairley; third vice-president, Mrs. K. Jewett; secretary-treasurer, Mrs. Bertha Colter; assistant, Miss Dorothy Parsons.

SAINT JOHN: A very interesting address on Rickets was given by Dr. A. L. Donovan before the meeting of the Saint John Chapter of Registered Nurses Association held January 18, 1932, in the Nurses Home of the Saint John General Hospital. Plans were made for entertaining members of the Canadian Nurses Association in June, 1932, in Saint John. Miss E. J. Mitchell, the President, was in the chair. A meeting of the Saint John General Hospital Alumnae was held February 1, 1932, at the residence of Mrs. H. H. McLellan. The President, Mrs. J. H. Vaughan, in the chair. It was decided to provide pyjamas for the Boys' Ward at the General Hospital. This ward has been furnished by the Saint John Chapter of Registered Nurses in memory of Nursing Sister Anna Stammers. It was also decided to give a bridge and dance, the proceeds to go towards buying a new lantern for the student nurses' lecture room. After the business session, Mrs. McLellan entertained the members at bridge.

MONCTON: On January 7th Miss Mac-Master and staff of the Moncton Hospital

entertained the local chapter of the New Brunswick Association of Registered Nurses at a dinner bridge in the hospital dining room. On February 11th, the Moncton Chapter held a Valentine Tea in the Annex of the Moncton Hospital. The reception rooms were decorated with hearts and red carnations centred the tables. A large number of guests were present. The proceeds of the tea will be sent to the Saint John Chapter to help defray expenses of the biennial meeting to be held in Saint John.

An address on "The Heart" was given by Dr. H. A. Farris at the meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses held February 15, 1932, in the Lecture Hall of the Nurses Home of the General Hospital. More than fifty nurses attended, and the address was greatly appreciated. Miss E. J. Mitchell, the president, tendered to Dr. Farris the hearty thanks of the members. Reference was made to the biennial meeting of the Canadian Nurses Association to be held in Saint John in June, the programme of which was announced recently. The Saint John organisation is planning suitable entertainment for the national meeting.

A bridge and dance, held in the Pythian Castle, February 23rd, under the auspices of the Saint John General Hospital Alumnae, was attended by about three hundred persons. The President, Mrs. John H. Vaughan, was convener for dancing, and Mrs. G. L. Dunlop was convener for bridge.

Sympathy is extended to Miss Maude Retallick in the loss of her mother.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in March, 1932, were 860, forty-two less than in February, 1932.

APPOINTMENTS

HAMILTON GENERAL HOSPITAL: Miss Grace Chapman (1929) has been appointed as Assistant in the Out-door Department of the hospital. Miss Viola Phillips (1920) is in charge of Ward 12, H.G.H.

DISTRICT 2

BRANTFORD: A miscellaneous shower was held recently in honour of Mrs. A. Van Evera, *nee* Reta Hockin, by a number of her classmates and friends. Mr. and Mrs. H. B. Cauvet (Helen Holbrooke, Brantford General Hospital, 1927), New York City, have been visiting in Brantford. Mrs. W. J. Rumney (Jessie McGregor, Brantford General Hospital, 1929) and baby daughter, Phyllis Joan, were recent visitors in Brantford. The Hon. Dr. John M. Robb, Minister of Health, paid an official visit to Brantford. The Brantford General Hospital, The Brant Sanatorium and the Department of Health were all inspected at this time. Mr. and Mrs. S. K. Culver, Waterford (Patricia Saunders, Brantford General Hospital, 1928) are spending the winter in Florida.

GUELPH: Miss Kenney, Guelph General Hospital, is assisting with the Home Nursing classes which are held once a week at the Y.W.C.A.

OWEN SOUND: The Owen Sound Alumnae Association held their regular meeting on February 26th in the Y.W.C.A. parlors. At the close of the business meeting, Dr. A. L. Danard gave a most interesting illustrated talk on his visit to Florence and Milan. The student nurses were present to hear Dr. Danard. At the close refreshments were served and a social half-hour was enjoyed. Miss Jean Currie (1926) is in Toronto at the Sick Children's Hospital, taking post-graduate work. The sympathy of her friends is extended to Mrs. J. McKeen (Winnifred Kirkwood, 1922), in the loss of one of her twin boys from diphtheria.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: The sixth annual meeting of the Registered Nurses Association of Ontario for District 4 was held in the class-room of the Senior Nurses' Residence of the Hamilton General Hospital on February 3, at 8 p.m. The meeting was called to order by the chairman, Miss A. Wright, and the reports of the various committees read and discussed. Miss Wright expressed regret for the absence of Miss E. Rayside, and voiced the hope that she might soon be restored to health and strength.

There was considerable discussion re the Permanent Education Fund and the following motion was carried and to be presented at the meeting in Ottawa in April. Resolution submitted to the Board of Directors of the R.N.A.O. from the annual meeting of District 4, February 3, 1932:—

"Whereas, District No. 4 desires to express its approval of the principle of the Permanent Education Fund, and

"Whereas, the nurses of this District on limited or reduced salaries, together with the lowered and uncertain salary of private duty nurses, and

"Whereas, the great need of consideration for the many hundreds of people, whose appeal in sickness and distress comes to us first because of our profession, and just now have the first claim to our sympathies,

"Be it resolved that the payment of the annual fee to the Permanent Education Fund be removed at least two years hence."

The 1931 officers were re-elected for 1932.

After the business of the evening was discussed, Mr. Herbert R. Hannah gave a very interesting lecture on "Russia". Mr. Hannah stressed the meritorious side of the present regime in that country, and one could not help but agree that Sovietism may possess attractions, especially when he informed his audience that unemployment is unknown among nurses in Russia; that they work the regulation seven-hour day and receive the national wage of \$110.00 a month. Mrs. S. Staton sang very acceptably.

Sympathy is extended to Miss Christine Livingston (1930) on the death of her father.

DISTRICT 5

TORONTO: A meeting of the Instructors' Section of the Centralized Lecture Committee was held on Wednesday March 2nd, at the Psychiatric Hospital—fifteen

members were present. A tour of the hospital, conducted by Miss Fidler, superintendent of nurses, was followed by the demonstration of a continuous bath, its uses and results being explained by Miss Ditchburn. After a brief business meeting, a social half-hour was enjoyed by all.

DISTRICT 5

COLLINGWOOD GENERAL AND MARINE HOSPITAL: The Nurses Alumnae of the Collingwood General and Marine Hospital met on Friday, February 25th. Reports were read and approved. The balance due on the furnishings of the nurses' room was approved for payment and arrangements made for the purchase of more linen. It was decided that the Alumnae would offer a medal in award to the nurse obtaining the highest standing in obstetrics. This award to be made at the time of the graduation exercises in June. A banquet was held on February 4th at the Arlington Hotel, fifteen nurses being present. Afterwards they were entertained at the home of the President, Miss K. Hanley.

DISTRICT 6

PETERBOROUGH: Chapter 3 of District 6, R.N.A.O., held their meeting on February 23rd, at 3 p.m., in the Green Room of the Y.W.C.A. with Miss Dixon, president, in the chair. It was especially gratifying that so many of the younger graduates were present, showing an interest in the activities of their profession. A communication was read from Miss Bell, Port Hope, requesting the Chapter to submit nominees for office for District 6. The 1931 officers were re-elected by motion of the meeting. It was decided to try to hold the meetings of the Chapter the same day of each month; the general opinion of those present was the last Tuesday of each month. Miss Stone kindly offered the use of her apartment for the meeting. As always, the social hour was much enjoyed. This time Miss Hurley gave an enchanting performance of two Valses by Chopin; following this, Mrs. Picard delighted her audience with a vocal solo, "Wake Up," accompanied by Miss V. Scollard.

NICHOLLS HOSPITAL, PETERBOROUGH: The Nurses Alumnae of the Nicholls Hospital held their annual bridge of the year in the Legion Hall, on February 11. Decorations were carried out in the Valentine colours. Ninety-six tables played, making the evening very successful.

QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: The following tribute was paid to Miss Grace Prescott, of the New Brunswick Division of the Canadian Red Cross Society. "The members of the executive of the New Brunswick Division are deeply grateful to Miss Prescott for her fine work in bringing up the division to its present state of efficiency." They have found Miss Prescott to be at all times most fair and impartial in her judgment, while her capable handling of the two positions, that of director of the division and the other of supervisor of the Red Cross in the last few months, is felt to be a feat deserving

of the utmost commendation. Miss Prescott is a graduate of the Royal Victoria Hospital, 1919.

VICTORIAN ORDER OF NURSES

TORONTO: Miss Elizabeth Smellie, R.R.C., Chief Superintendent of the Victorian Order of Nurses for Canada, was guest of honour at a dinner given by the nurses of Toronto, Weston and East York Branches, at the Alexandra Palace, Toronto, on February 27th. Mrs. J. M. Godfrey, convener of the Advisory Nursing Committee, Toronto Branch, Miss Kathleen Russell and Miss Jean Gunn, members of the committee, and Miss Edith Campbell, superintendent of Toronto Branch, were also guests. The tables were decorated in yellow and mauve spring flowers with candy baskets in the same shades. Miss Smellie spoke after dinner of developments and plans for the work of the Order throughout the Dominion.

C.A.M.N.S.

VANCOUVER: The Vancouver Unit, Overseas Nursing Sisters' Association of Canada, held its annual meeting in the auditorium of Shaughnessy Military Hospital, upon the invitation of Miss Matheson and Dr. Jones. About forty members were present. A report was brought in regarding the taking out of a charter with the Canadian Legion, and was left for further discussion at a later date. The question of associate membership in the local association was also discussed, and annual reports showing a very successful year were given by the secretary-treasurer and the president. It was stated that there was now a membership of seventy, four of whom live out of town. Regret was expressed at the forthcoming departure for Toronto of Mrs. Ronald Haig. Election of officers for the year resulted as follows: president, Miss Jane Johnston; vice-president, Miss Pat Stewart; secretary-treasurer, Mrs. J. M. Brough; executive committee, Miss Alice Brand; convener of social committee, Miss E. V. Cameron; membership committee, Miss Blanche Swan; sick visiting, Mrs. Harry Black. After the meeting, a social evening of bridge followed.

WINDSOR: A regular meeting of the Nurses' Overseas Club was held at the home of Miss Mary Shand, Walkerville, on February 14, 1932. It was reported that Christmas cheer had been sent to the returned men in hospitals in the form of smokes—tobacco, cigarettes and cigars; flowers were also sent to sick members. Four new members were enrolled. At the close of the business session bridge was played. Officers for the year were elected as follows: Chairman, Miss Nellie Gerard; vice-chairman, Mrs. Gilbert Storey (Marion Starr); secretary-treasurer, Miss Frances McNally, of the Metropolitan Hospital; membership convener, Miss Myrtle Geldar, Receiving Hospital, Detroit.

WINNIPEG: The tenth annual meeting of the Nursing Sisters' Club of Winnipeg was held in the banquet room of McLeod's Restaurant, February 22, 1932, and took

the form of a dinner gathering, attended by twenty-seven members. The tables were gay with daffodils and tulips set off by green tapers in silver candlesticks. The toast to the King was given. Absent friends and comrades were honoured. Reminiscences were in order, and many happy events of service days recalled. Those present included: Miss S. Pollexfen, in the chair; Mesdames Dan McDougal, Jean G. Harry, Stella Gordon Kerr, C. E. de Pencier, G. M. Hamblin, M. J. Johnson, E. W. Horton, A. D. McLeod, Fletcher Argue, C. W. Davidson; Misses L. M. Gray, E. Letellier, A. E. Andrews, I. A. E. Lloyd, E. A. Bennett, Ann Canning, M. C. MacGillivray, Josephine A. MacDonald, Gertrude Billyard, Elizabeth

Stewart, Annie C. Starr, T. O'Rourke, Norah O'Shaughnessy, Mrs. Annie Bond, a South African veteran, and Mrs. T. Howard, veteran of the N.W. Rebellion. Following the dinner, annual reports were submitted by conveners of various committees and the members of the executive elected for 1932-33 as follows: president, Miss S. J. Pollexfen; first vice-president, Miss A. C. Starr; secretary-treasurer, Miss T. O'Rourke; convener social committee, Mrs. C. W. Davidson; press and publicity, Miss Josie McDonald; sick visiting, Miss C. Canning; membership, Miss A. Blais; memorial, Mrs. H. Coppinger; advisory members in addition, Mrs. J. F. Morrison, Mrs. A. D. McLeod and Miss M. MacGillivray.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BROWER—On January 10, 1932, at Edmonton, Alta., to Mr. and Mrs. Brower (Sybil McLeod, Royal Alexandra Hospital, Edmonton, 1925), a daughter.

CHRISTIE—On February 27, 1932, to Mr. and Mrs. R. J. Christie (Bessie Clark, Hamilton General Hospital, 1928), a son, Robert Douglas.

CHURCH—In March, 1932, at Montreal, to Mr. and Mrs. C. Church (Elizabeth Baxter, Royal Victoria Hospital, 1930), a son.

CUNNINGHAM—On May 30, 1931, to Mr. and Mrs. William Cunningham, Vegreville (Ruth Boutillier, Lamont, 1924), a son.

LANE—On February 4, 1932, in Montreal, to Mr. and Mrs. Hamilton Lane (Isabel Macfarlane, Royal Victoria Hospital, 1928), a daughter.

MCDUGALL—On January 4, 1932, at Edmonton, Alta., to Mr. and Mrs. John A. McDougall (Rose Louise Eastman, Royal Alexandra Hospital, 1926), a daughter.

MORRISH—On December 28, 1931, at Edmonton, Alta., to Dr. and Mrs. W. Morrish (Lilian Fraser Strachan, Royal Victoria Hospital, Montreal, 1919), a son, Hugh Fraser.

REID—On June 17, 1931, at Lamont, to Mr. and Mrs. R. W. Reid, Vermilion (Bessie Mellett, Lamont, 1927), a daughter.

WHEATCROFT—In July, 1931, to Mr. and Mrs. A. Wheatcroft, Edmonton (Merle Pasmore, Lamont, 1928), a daughter.

WILKINSON—On January 30, 1932, at Leduc, Alta., to Mr. and Mrs. N. Wilkinson (Jean Allen, University Hospital, Edmonton, 1928), a daughter, Florence Elizabeth.

YOUNG—On February 29, 1932, in Montreal, to Dr. and Mrs. Young (Norma Macfarlane, Royal Victoria Hospital, 1921), twin daughters.

MARRIAGES

ALTON-BREDSTEIN—Recently, at Ashmont, Zelma Bredstein (Lamont Hospital, 1930) to Malcolm Alton, of Lamont, Alta.

BEHLING-PANABAKER—Recently, Marjorie H. Panabaker (Kitchener & Waterloo Hospital, 1930) to Gordon Edward Behling, of Kitchener, Ont.

CLEARY-PALMER—Recently, at Edmonton, Eleanor Palmer (Lamont Hospital, 1924) to John Lester Cleary, of Pouce Coupe, B.C.

DACK-DARLING—On February 18th, 1932, at Brantford, Norma May Darling (Brantford General Hospital, 1925), to John Oldham Dack, of Brantford.

FOLLIS-BISHOP—On December 30th, 1931, at Medicine Hat, Zola Bishop (Medicine Hat General Hospital, 1931) to Erwin Follis.

HAROLD-LEES—On December 10th, 1931, at Edmonton, Jessie Lees (Lamont Hospital, 1930), to Gordon Harold, of Lamont, Alta.

LAMONT-DOVER—In December, 1931, at Toronto, Ontario, Donelda Dover (General and Marine Hospital, 1930) to Blakely Lamont, of Stayner, Ont.

MITCHELL-BASSETT—On December 29th, 1931, at Medicine Hat, Vera Bassett (Medicine Hat General Hospital, 1927) to John Mitchell.

NEVILLS-ROBB—Recently, Elizabeth Robb (Hamilton General Hospital, 1931) to Earl Lane Nevills, Hamilton, Ont.

PORTER-SODERO—On March 2nd, 1932, at Medicine Hat, Thelma Sodero (Medicine Hat General Hospital, 1927) to Emmerson Porter.

SMITH-WALKER—In October, 1931, at Collingwood, Ontario, Lily Walker (General and Marine Hospital, 1931) to Gordon Smith, of Stayner, Ont.

VAN EVERA-HOCKIN—On August 29th, 1931, at Toronto, Reta M. Hockin (Brantford General Hospital, 1927) to Arthur W. E. Van Evera, Brantford.

YUILL-VAN BUSKIRK—On January 27th, 1932, at Estevan, Marjorie Van Buskirk (Northwestern Hospital, Minneapolis, 1925) to H. Yuill, of Medicine Hat.

DEATHS

WHITE—On February 15th, 1932, at Peterborough, Ont., Edith White (Nicholls Hospital, Peterborough, 1927).

REGISTRATION of NURSES

PROVINCE OF ONTARIO

Examination Announcement

An Examination for the Registration of Nurses in the Province of Ontario will be held in May.

Application forms, information regarding subjects of examination, and general information relating thereto may be had upon written application to—

**Miss A. M. MUNN, Reg.N.,
Parliament Bldgs., Toronto**

Copies of Survey Report

are available at 511 Boyd Building, Winnipeg, Man.; University of Toronto Press, Toronto, Ont., and Secretaries of Provincial Associations of Registered Nurses.

**Lots of ten copies, \$1.75 each, or
single copies, \$2.00 each.**

WANTED—Position as Instructress, or Supervisor of Nurses' Home by graduate with college degree. Apply Box 123, 511 Boyd Building, Winnipeg, Man.

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The Shriners' Hospital for Crippled Children, Montreal, Quebec, offers to graduates of accredited Schools of Nursing a two months' course in Orthopaedic Nursing. For information apply to:

**Director of Nursing,
Shriners' Hospital for Crippled
Children,
24 James Street, Albany, New York**

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

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**A.A., LADY STANLEY INSTITUTE, OTTAWA
(Incorporated 1918)**

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

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Regular monthly meeting every third Wednesday, 8 p.m.

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A.A., SCHOOL FOR GRADUATE NURSES, MCGILL UNIVERSITY, MONTREAL, P.Q.

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Some Phases of Bacteriology and Immunity

By MILDRED M. REID, Reg.N., Instructor of Bacteriology, School of Nursing, Winnipeg General Hospital.

The subject of bacteriology is far wider and more comprehensive than might be judged from the name, for it now commonly includes the subjects of immunology and serology. One finds that nurses approach this course of study with the idea that it is confined to a laboratory and therefore is of no practical significance to them. The student should realise that nearly all of the routine procedures taught in the nursing course are based on a knowledge of the part bacteriology plays in medicine. Cleanliness, asepsis, sterilisation, etc., are practised with the purpose of eliminating the ever present bacteria. Then too, since approximately ninety per cent. of all diseases are caused by some form of infection, methods of treatment are largely determined by an understanding of the nature and results of bacterial invasion.

In teaching student nurses the writer finds that the subject of immunology is the most difficult for the student to comprehend. The problem is so vast that one may attempt to impart only the simplest of facts. The subject of immunity has developed a terminology peculiar to its many problems. Many medical men are frequently at a loss to interpret the terms and quite naturally the nurse cannot be expected to do so. Even so, some simpler and broader concepts of immunity exist and these the nurse and even the layman can comprehend.

The first contact nursing students make with these problems of immunity is when they are subjected

to various tests and inoculations relative to the acute infectious diseases, such as smallpox, typhoid fever, scarlet fever and diphtheria. Every student should acquire some knowledge of the cause and effects of the inoculations, and of the purpose and value of the tests which she receives. While some students are curious enough to ask about these procedures, many do not; therefore an excellent opportunity offers itself to the doctor or nurse assistant, who is responsible for the giving of these inoculations, to impart such knowledge. At this time it would be an excellent idea for these students to be given one or two hours of instruction as to the "why and wherefore" of the procedures—or would the preparation of a paper followed by a thought-provoking quiz make a more lasting impression?

Two factors are especially concerned in the question of immunity and infection, the infective agent and the defensive forces of the body. Included in the latter are the physical and chemical barriers offered by the skin, mucous membranes and various secretions, the special cells of the blood and tissues (the phagocytes) which destroy bacteria, and the protective substances found in the blood plasma. These protective substances or antibodies include the bacteriolysins, agglutinins, precipitins and antitoxins that destroy or neutralise bacteria and their toxins. As a result of the presence of these various factors one possesses immunity.

Immunity, a state of the body's resistance to infection, may be natural or acquired. Natural immunity is a resistance to disease that one inherits, but such a state is subject to variation, the influence of apparently slight factors, such as other infections, or a change in the weather, or some degree of fatigue may at times be sufficient to alter a condition of resistance into one of susceptibility.

Acquired immunity may be "actively" or "passively" acquired. To develop active immunity the tissues of the host must produce their own antibodies, whereas in passive immunity the individual's body is the recipient of protective substances formed in, and taken from another person or animal.

Active immunity may be acquired in various ways, by an attack of the disease, or by inoculation of living, attenuated or dead bacteria, or by the introduction of bacterial toxins.

During an attack of any single one of the majority of diseases the patient develops a more or less permanent immunity to that disease. True, in certain conditions such as pneumonia the patient on occasion appears to be more susceptible following one attack; this apparent anomaly may be explained by the fact that pneumonia occurs as the result of the activity of diverse species of bacteria. Several strains of the pneumococcus are known to exist, hence a patient may be subjected to a further infection from a different strain.

The inoculation of a preparation containing attenuated living organisms or a virus, as for example the vaccine used for smallpox which produces a mild form of infection, gives rise to a definite immunity. In a vaccine of this type the virulent organisms have been rendered non-virulent or attenuated either by passage through an animal or by artificial

culturing under special conditions for varying lengths of time.

The vaccine for typhoid fever contains dead bacteria including their endotoxins, suspended, usually, in normal salt solution. Such solutions contain much the same irritating substances as the living bacteria, and produce immunisation in a similar manner but without producing the discomforts associated with the disease.

Inoculation of specific toxins have proved highly successful in the prevention of certain diseases, more especially those caused by bacteria which produce true exotoxins. Immunisation against diphtheria may be obtained by the inoculation of toxoid, a product prepared by treating diphtheria toxin with formaldehyde, this procedure renders the preparation less irritating without interfering with its antigenic properties. These preparations, vaccines or toxins, must have the ability to irritate or stimulate the body tissues so that the tissues produce protective antibodies sufficient to develop immunity. When a nurse receives typhoid vaccine or diphtheria toxoid, substances are formed in her body which are antagonistic to the typhoid and diphtheria bacillus and their toxins.

In passively acquired immunity the individual receives protective substances or antibodies that have been developed in a healthy animal, usually a horse. The animal has been inoculated over a period of time with a vaccine or a toxin. After sufficient time has elapsed for the production of the antibacterial or antitoxic substances, the animal is bled under aseptic precautions, the blood collected into a sterile container and allowed to clot leaving a clear amber liquid, the serum. The serum, after removal from the clot, is modified, a process which reduces the undesirable protein content, and after the addition of a preservative to insure

continued sterility, it is standardised into units depending upon the amount of protective substances contained in a measured amount of serum. Antiserums may be administered in order to produce a temporary immunity in those who have recently come in contact with the disease, or as is more frequently the case, it is given to a patient with the purpose of combating an acute infection.

Every nurse should be able to recognise the difference between the terms vaccines and serums. A clear definition is of value. A vaccine is a solution of attenuated living microscopic or ultra-microscopic organisms; a solution of dead bacteria and their endotoxins; or of toxins or any preparation that acts as an antigen. Vaccines are specific; they cause the creation of an active immunity. This immunity is developed by the host in a relatively short time. It may be permanent, that is, it remains for a life time, or it may gradually disappear with the years. For instance, public health authorities advise the reinoculation of smallpox vaccine at the end of seven-year periods, since by this time some persons may have lost their immunity to this disease.

A serum, or blood serum, the clear part of the blood that appears on clotting, contains the specific antibodies. The immunity conferred by serum is of short duration, for the body handles the serum as foreign material and eliminates it, as a rule within six weeks. However, because of the immediate beneficial results, serums are of great value in the treatment of disease. These serums are given the name of antiserums or antitoxins, for instance "Diphtheria antitoxin."

Any discussion of this subject would be incomplete without mention of the tests that are commonly employed in an endeavour to detect susceptibility to disease. The tests with which the student becomes

familiar are the Schick, Dick and in some cases Tuberculin tests.

A method of determining the susceptibility of a person to diphtheria, was devised by Schick in 1913. The Schick test is made by injecting, intradermally, a minute amount of diphtheria toxin, usually on the forearm. If there is no diphtheria antitoxin present in the host to neutralise the toxin thus introduced, the tissues at this point will become irritated by the diphtheria toxin, indicated by the formation of a red, apparently inflammatory area, which appears in twelve to twenty-four hours, and this reaction reaches its maximum on the third and fourth day. The reaction gradually subsides leaving a definitely circumscribed scaling area of brownish pigmentation which may persist for a short time. Such a reaction is called positive and indicates a susceptibility to diphtheria. But if the individual is immune to diphtheria, the antitoxins in his blood immediately neutralise the toxins injected, no irritation occurs, and we say, therefore, that the reaction is negative. As many individuals are resistant to diphtheria, having already developed antitoxins which then persist in the blood, this method affords a means of selecting for artificial immunisation only those in need of such protection. The Schick test and all other tests need to be carried out and interpreted by one experienced in the technique and the nature of the reaction.

Certain tests in older children and adults give rise to a "pseudo-reaction," this results from the undesirable proteins contained in the material injected, and not from the specific toxin. To determine if an apparently positive reaction is the result of these extraneous proteins, a control test, as it is called, is made, simultaneously with the test, and the area selected is usually above the toxin injected area, or on the opposite arm. The material used for this

purpose in connection with the Schick test is diphtheria toxoid. Also this test enables one to judge with considerable accuracy, the probable reaction of a person to toxoid. A reddened swollen area indicates a positive control test, in which case the toxin or toxoid if required for active immunisation, should be given in divided doses, thus avoiding any undesirable reactions.

The procedure and reading of the Dick test, given to detect an individual's susceptibility to scarlet fever is similar to that of the Schick test. The material injected consists of a small amount of toxin produced by the scarlet fever streptococcus, and the reading of the reaction should be made twenty-two to twenty-four hours after the injection.

In some training schools nurses are given the tuberculin test. Tuberculin is a preparation of the tubercle bacillus. There are several methods of applying the test. Recently the intracutaneous inoculation or "Mantoux" test has come into favour. If a tuberculous focus exists in the body, then the use of tuberculin is followed by a reaction. The interpretation of the reaction should only be made by one experienced in the procedure.

A practical application of this test applies to the student nurse entering

the training school. If the test indicates that the young woman had not incurred a previous mild infection then she would probably be a poor health risk, as she has acquired no special immunity to the disease. Since, as yet, we have no proven method of artificial immunisation, she should not consider undertaking the strenuous and fatiguing three years' course of training, where she will inevitably come in contact with active tuberculosis. Also the young woman who shows an extensive positive reaction may be an undesirable candidate for the training school. She may have active lesions or she may have recently recovered from an attack, in which case the strain of the work during training may induce a relapse.

This paper only touches upon a few of the phases of bacteriology and immunology. Wider reading by the nurse is necessary before she can realise how fundamental these concepts are in the practice of medicine. She can appreciate, however, the reasons both for the benefits derived from the practical application of the tests and for the beneficial results obtained from the administration of serums and vaccines in the prevention and treatment of disease.

Education and Health

By ROY FRASER, Professor of Biology and Bacteriology, Mount Allison University, Sackville, N.B.

In dealing with the relation of education to health, I shall limit myself to pointing out a biological obligation laid upon us by Nature herself. That obligation demands that we fit every child and every adult for the business of living, and living is basally a very physical business.

This is the first duty of education.

It is far from being the highest function, but it is a necessary prerequisite to all the higher activities and objectives of that process.

As a teacher, I am proud of the service that education—despite its faults—is rendering toward the betterment of human life. But I would be less than honest, and lacking in courage, if I did not charge our present system with being entirely inadequate in the matter of physical

education. Our schools and colleges do not prepare our pupils and students to meet successfully the physical experiences and responsibilities of life. We have largely ignored a great principle of those major prophets of education: Plato, Locke, Mulcaster, Rousseau and Pestalozzi, all of whom placed health teaching at the very foundation of education.

All education must be based on natural processes. Nature cares nothing for our system. If, by omission or commission, we ignore or violate biological law, she penalizes us according to the measure of our offence. She has three degrees of penalty:

(1) Her first penalty is the impairment of happiness in living, the lowering of efficiency in working, the perpetuation of the social injustices wrought by bad heredity and bad environment, and an enormous wastage of time and money.

(2) Her second penalty is death. She has throughout the ages sent not only individuals but whole races of the unfit to their death. It is she who first made the decree that "ignorance of the law is no excuse." Whether it be a lower animal, a child, a man, or a civilisation, the law operates inexorably.

(3) Her third penalty is more dreadful than death, for death is a clean thing and an ending. The third penalty is to be condemned, not to die, but to live! To live, with a wrecked body, a wrecked mind, a wrecked spirit; to live with your life blasted before you were born by a diseased or feeble-minded parentage; to live uselessly a burden upon the lives of others; to live pleasurelessly, barred forever from the joyous vitality of a healthy body; to live painfully, shackled by deformity and knowing only the long vigils of pain; to live hopelessly, drearily, waiting only for the turnkey of Death to unlock the prison of flesh and grant at last the mercy of release.

If you require substantiation for what I say, look about you. You have not seen these things? Then you had

better make it your business to see them, for they affect a social and economic order of which you are a part. They are your business, and you are their business, and no theory of democracy, no form of government, no attitude of religion, and no system of education, can ignore them—no, nor disclaim some part of the responsibility for their existence.

For government must serve the physical as well as the political well-being of the people; democracy must postulate physical as well as social freedom; religion must reckon with biology and not attribute the results of physical ignorance to "the will of God;" and education must face squarely the physiological laws that govern learning as well as living.

If those august but somewhat myopic persons who control our educational policies knew a little more about the human body, they might be able to achieve better things for the human mind. Good hygiene is the first step toward productive learning. We might at least begin by seeing to it that every school provides healthful working conditions for pupils and teachers, and that is not the case in many of our schools today. If that offends anybody, I am at your service with specific instances.

I am not asking you to look at this matter through the eyes of science. If you were, then this address would be entirely unnecessary. Will you simply look at it through the eyes of common sense? Here are our educational institutions, of all sorts and grades, from the kindergarten to the university. They are flung across the land in thousands. Millions of young lives pass through them at a time when life is still in the making and habits are still in the shaping.

These institutions are teaching nearly every branch of knowledge under the sun. We believe that there are cultural values and helpful mental disciplines in all these subjects, if they are properly presented. But what of the practical values of

preparing young lives for meeting successfully the bodily experiences of life? We can only answer that in all this formidable and time-consuming array of subjects in the curriculum, we have given a negligible place, and often no place at all, to physical education.

The child is forced by compulsory drudgery to memorise the most interest-killing details of political history, but he is taught nothing of the history of our physical progress throughout the ages. He is taught to glorify men who were wholesale destroyers of human life; he is taught nothing of those men of science who have been its greatest saviors. He is forced to memorise the imports and exports of many countries, but he is taught nothing of those invisible imports and exports of the human body, the bacteria responsible for the vast problem of the communicable diseases. He is taught the geography of continents better than he is taught the structures of his own physical being. He is taught in trade-schools how machines are operated, but he is not adequately trained in the intelligent control of that most wonderful of all machines, his own body.

Or perhaps he may go to a theological college and become learned in the ways of the spirit, completely ignoring the fact that the flesh-vehicle of the spirit can have most profound influence on personality, character, attitude, ideals, reasoning power and even upon the ancient doctrines of free-will and sin.

In school and out of school he is taught an exaggerated respect for some of the material inventions of our civilisation, but he is not taught that that same civilisation has developed environments which are unnatural, and living habits which are unhygienic, and that we must face the biological liabilities as well as the inventive assets of our civilisation. For while man has gone forward in the control of the communicable diseases, he has not reduced but greatly increased the degenerative

diseases, many of which are the direct product of modern living-habits.

But, you say, further research will solve all that. Research, unsupported by education, will not solve it. An immense amount of scientific knowledge has never been brought into practical action. Hear what Dr. Calver of the American Public Health Association has written about that: "This knowledge is stored away in textbooks and journals, hidden from the layman among incomprehensible words and symbols, and disguised with appalling statistics. The research worker has found the knowledge he sought, but we have failed to make this knowledge available for the service of mankind. The production of knowledge has far outstripped its consumption."

And what is the result? Millions of people are constantly suffering various degrees of physical incapacitation from preventable diseases. Why? There are several causes, but the chief reason is that they have not been sufficiently trained in the knowledge and disciplined in the living habits that would have helped to prevent disease.

If you are not interested in this from a humanitarian standpoint, will you listen to what it is costing us from an economic standpoint? For the following figures I am indebted to such authorities as Dr. Louis Dublin, the foremost life-insurance statistician in the United States, the president of the American Public Health Association; Dr. Stuart Chase; Dr. J. S. McCullough, chief of the Ontario Department of Health, and most particularly to a recent article by Dr. J. M. Cassidy of Toronto University.

Here are the cold facts:

In recent years, physical impairment has cost the people of the United States the sum of \$75,000,000,000.

In Canada the same condition obtains in relative proportions.

At any given time, 70,000 of the Canadian working population are absent from work owing to illness. Every year the Dominion of Canada has to spend on the maintenance of her hospitals, sanatoria and asylums, alone and not counting other medical costs, a sum exceeding \$50,000,000. The annual cost of preventable disease and preventable premature death in the United States comes to \$8,250,000,000. In Canada our cost of the same items comes to \$1,300,000,000, of which \$300,000,000 is due to preventable disease. Various authorities state that from 50 per cent. to 85 per cent. of this loss is definitely avoidable. Canada could, therefore, in any one year save at least \$150,000,000 and possibly \$200,000,000, which as Professor Cassidy points out, is a sum far in excess of our present national deficit, if she would throw herself whole-heartedly into the battle for the conservation of health and the reduction of preventable disease.

Education won't do it, you say. It has done it, in instance after instance, where it has been given a fair chance. Whole communities have been educated into new attitudes by the accomplishments of public health workers. For example: Hamilton, a few short years ago, in 1922, had 747 cases of diphtheria with 32 deaths. Then came a campaign of immunisation and worked a miracle, for in 1931 they had only five mild cases and not a single death! Do you think you could tell Hamilton today that the prevention of disease is only an unworkable theory or a dream?

The whole situation comes to one clear focus: that we can effect a tremendous saving of life and health and money if we want to, and education must do its share in bringing that about. With the advice and guidance of the medical and public health professions, we must establish in every grade and type of education, a continual wisely-selected and

vigorously presented course of health instruction, suitable for each age range.

But, you say, are we not teaching hygiene in the schools? Yes, and I am sorry if I hurt anyone's feelings when I say that most of it is very poor stuff indeed. It has some value, but it includes much that should be left out, and it deals very feebly with things that should be emphasized and drilled into the pupil until proper health habits are firmly established. In this regard, the Junior Red Cross has rendered valuable service.

In the field of higher education, the majority of college hygiene courses are in need of great improvement. A large number of university students receive nothing that can be called an effective training in hygiene. Physical education should be not only a required course, but the very basis of higher education.

Institutional training must be supported by adult education of the population at large. Magazine articles, radio talks, and public health department literature have been of real value. Special credit should be given to the health service newspaper articles issued by the Canadian Medical Association under the direction of Dr. Grant Fleming.

All these things are good, but they are not enough. Mass education in health must be personal and direct, and requires the use of such agencies as public illustrated lectures and exhibits, and the establishment of hygienic museums of the Dresden type.

But all these methods must be supplementary, not primary. *The foundation of health education must be laid in the schools and colleges.*

Surely our educational system will no longer delay an adequate inclusion of that fundamental knowledge that is demanded by Nature, by economic necessity, and by the conservation and increase of human health and happiness.

Sanatorium Economics

By R. E. WODEHOUSE, M.D., D.P.H., Executive Secretary,
Canadian Tuberculosis Association.

I gave a paper recently before the Tuberculosis Section of the American Hospital Association and I have decided that its subject matter possibly will be the most interesting material that I can present to you this afternoon.

The report of the Health Section of the League of Nations is said to show that the mortality from tuberculosis has diminished in practically all countries in which statistical data are available. One might also conclude that the contents bear out the findings of Dr. George Ferguson in his study of tuberculosis among the Plains Indians in Canada, namely, that tuberculosis in its incidence is true to the form of many other infectious diseases in that it is epidemic as well as endemic in behaviour. It is interesting to note a remarkable parallelism in the relative fall in different countries and cities during the last quarter of a century. England, Wales, London, Austria and Vienna show declines all within a spread of five per cent., namely, between 56 and 59 per cent. The peak of mortality has not occurred in different countries at the same time. It occurred in 1871 in Scotland, 1880 in New Zealand, 1900 in Ireland and Norway, 1901-1905 in Hungary, 1905 in Czecho Slovakia, and 1909 in Japan. We in Canada have an example of its ascending in the Brant Reserve Indians, its climax, and its recession. It seems to be self-limited in its cycle, but its recession can be very materially hastened, as can most infectious epidemics, by the intelligent, earnest application of the methods of control which we have already proved to be successful.

It has always been held in our office that the best form of education

in the homes, and the public in general, is the educator, not pamphlets and other printed material. The most influential educator entering the homes is the public health nurse and her sister nurse who carries on bedside work. If sanatoria are justifiable institutions, we ought to be able to convince the nurses this is so, and if we do convince you, I know you will at the opportune time and in the proper place pass on the word to the members of the public with whom you come in contact, and the public invariably are receptive to all things that you are good enough to tell them.

My opinion is that institutions for the care and treatment of tuberculosis have been the most important factor in hastening the recession of the tuberculosis death rate cycle on this continent. The sanatorium forms the keystone of the arch of helpful accomplishments in Canada. It can be proved that the secret of their success is in the segregation of open infective cases from the homes of the poor, in which usually the very high percentage of child contacts exist. Caring for those from the better homes who can pay even \$10 a week for their treatment, or whose friends or societies can pay for them, is not the effective factor from a national point of view. Take every infective case out of the homes of the poor and the death rate will tumble.

How Many Beds Would This Require?

There are about *7,000 sanatorium beds operating in Canada for the care of the tuberculous. They cost annually for upkeep approximately \$7,000,000, care for nearly 15,000 tuberculous annually, and have an

(*This number is being increased by new construction in progress to 8,300, to be operating in 1932, being more beds than deaths in Canada during a year, from all forms of tuberculosis.)

estimated replacement value of \$18,000,000. Deaths from tuberculosis registered for 1930 were 8,071. Probably if a bed a death were provided for the North American Indians, whose deaths are included in the above and whose rate per 100,000 is very high, there would be a bed a death occurring each year among the balance of the population.

Some of the provinces have in excess of one sanatorium bed per death occurring each year from tuberculosis. Ontario, for instance, has 2,340 beds and in 1930 had registered 1,789 deaths from tuberculosis. Manitoba and Saskatchewan have respectively the relationship of 585:456 deaths and 705:407 deaths from tuberculosis. I believe that with the diagnostic services there are available and working very successfully, the economics of providing three sanatorium beds per death occurring each year from tuberculosis could be justified. However, within the institution of the utilities even two will be a tremendous help. Saskatchewan, with its complete diagnostic services (over 10,000 individuals examined last year in the institutions and by the institutional medical staffs outside the sanatoria and with free treatment for all, regardless of financial status) is, tentatively anyway, of the opinion that it can control its situation with the present 705 beds. Of course, its population is almost entirely rural and its death rate has consistently remained around 45 per 100,000 population.

Cost of Beds

In view of the present urgent need of increased facilities of the type we think are having the maximum effect in reducing the ravages of disease, I have always held that costs of construction and equipment should be kept at a minimum. Some of our sanatoria, like some of our public schools are ornate beyond all sane requirements. The construction should, in my opinion, be as nearly

fireproof as possible. The layout of the floors should be that which provides the maximum amount of service at the minimum cost of personnel. This point is a most material one, after comparing costs of maintenance in a recently constructed institution with others carrying on under very similar conditions. The difference in maintenance proved to be forty cents a day lower in the new one, which on over 200 beds occupied means an annual saving of \$32,120, or an amount equal to the interest on \$642,000 at five per cent. These are cold facts. Therefore, probably my urgency for more beds per \$1,000,000 spent is subject to discussion. I tried to picture satisfactory institutions at \$2,000 a bed but am convinced \$3,000 is necessary to provide the essentials suggested above. It is unfair to spend in excess of this, especially when money is so difficult to obtain and the urgent need is so evident.† Sanatoria have been constructed in the last three years in Canada which warrant \$3,000 as a fair cost, including all essential provisions such as heating, power, laundry, culinary, x-ray, and staff accommodations. We should utilise the most satisfactory layout of floors, etc., and not have each institution allowing an architect to lay out and then experiment in each newly conceived institution. Canadian architects have already demonstrated perfect equipment for our needs and climate. Why not have other architects use the successful man's ideas by way of consultation? If the absence of diet kitchens on each floor is a source of economy, where every patient is tray fed and two dumb waiters or continuous chair conveyors of trays will solve the matter, why not duplicate it?

(†Mount Sinai Sanatorium at Ste. Agathe des Monts, Quebec, is completely fireproof, most artistic and efficient, self-contained except for nurses' home, 561,000 cubic feet, 100 beds, \$2,400 a bed, including steel lockers, refrigerators, electric fixtures, etc., as well as roof adapted for open air treatment. Religious requirements increased the space requirements to double kitchen and chapel and synagogue.)

Design

As to porches, the set-back arrangement of each succeeding floor is favoured but I am told it is wasteful and expensive. I am not yet convinced of this. We have several splendid examples in Canada now. I am making movie films of the exterior and floor plans of all our new buildings. It is hoped their circulation will prove helpful. There are no north exposure balconies as yet. We have closed-in balconies with movable glass ceilings which can be moved to the extent of sixty per cent. and it is estimated it makes porch use possible at least six weeks earlier in spring for sun cure and correspondingly later in the autumn. They have proved entirely satisfactory in our most northern sanatorium where snow falls in abundance. Two more very important features are the heating of wards without porches and the acoustics of the building. Plaster finish which absorbs sound and lessens noise is most important, is not expensive, and has proved scientifically and actually most satisfactory, both acoustically and from the point of view of cleanliness. The additional cost is infinitesimally small. As to heating, the steam-heating scheme of Dr. Kendall's institution at Muskoka, where in zero weather the whole front wall of windows disappears and outside temperatures prevail during the night, to be changed at breakfast in seven minutes to comfortable dressing temperature, without risk of pipes freezing, is ideal to my mind. I do not like the idea of unheated wards.

Location

Location of the institution is most important, as well as the location etc. I remember distinctly an experience in Stratford, Ontario, being requested as District Health Officer to visit the general hospital and discuss with the board plans for a tuberculosis wing. I confessed I had very little knowledge of architecture but that I thought it was most encourag-

ing that the board should, at least, seek, before deciding finally on plans, the opinion of medical men. I asked them whether they also had asked the opinion of the superintendent of nurses and they admitted they had not. I emphasized the fact that she was the one who was going to be responsible for the economic administration of the wing of the general hospital, once it was completed, and that she would know more than even the doctors as to the best possible layout of the structure, so that it would save unnecessary steps of nurses, save unnecessary transferring of patients to bath-rooms, toilet rooms, dressing rooms, save in the cost of personnel in serving the patients if the diet kitchens were properly placed or, if, as in Saskatchewan, there were no diet kitchens and all tray fed. Cost of personnel is the important item in the maintenance costs of institutions. If the number of personnel required can be reduced, there will be a decrease in the daily cost of salaries, breakages, as well as housing and food. The next essential item is to locate the sanatorium where ample fire protection is available, where pure water is supplied under proper supervision—laboratory and engineer, where garbage disposal is cared for if possible, and where sewage disposal is inexpensive and impossible to become a worry to the medical administration, and, finally, it should be located near transportation, to make coal haulage, food, and other supplies both winter and summer as cheap as possible, and free from any interruption. This practically means location within the city boundaries and this I certainly favour, as it also makes emergency surgical requirements in general hospitals much easier and it makes the advice of other medical men outside the staff of the sanatorium easily obtainable at all times, and without inconvenience to these men who often give their services free to such institutions.

Clinical Services

It is most important for the sanatorium medical staff to have the privilege of general clinical diagnostic work, as found in an outdoor clinic service devoted to chest work. It is best that the diagnosis of cases should be carried on by members of a staff who are devoting their full time to such practice. It is particularly important that all records of examination of patients admitted and contacts in the home should be correlated in one family or household file, and that progress examinations with films should be under one envelope cover, together with the clinical and social history. The follow-up examination records of discharged cases all maintained by this same central unit presents the most hopeful organisation for this work. If the city maintains this system of records in its health department insofar as chest clinics and treatment institutions are concerned, it is entirely satisfactory, but it should be an incentive to clinical care to have duplicates of such family records in the institutions. In nearly all of our sanatoria in all of the provinces of Canada, field services are working outside the institutions, in part or in whole, according to the above suggestion. As an evidence of their influence may I quote striking figures provided by two of these, namely, Brant Sanatorium at Brantford, and the Niagara Peninsula Sanatorium. Both of these institutions carried on for years without full-time medical officers. Dr. Holbrook of the Hamilton Health Association, at our request, undertook to establish regular chest clinics in each centre. Finally full-time medical officers were appointed to conduct the clinics and care for the sick. The bed accommo-

dations were increased in quality and also in quantity fourfold. The results of the clinics are as follows, as evidenced from the cases admitted to the institutions:

Dr. Shaver, medical officer of the Niagara Peninsula Sanatorium near St. Catharines, writes comparing the state of the disease in patients admitted during 1929-1930 from his four urban communities where chest clinics have been operating for varying periods—St. Catharines, six years; Niagara Falls, three years; Welland, three years; and Port Colborne, one year.

Classification at Admission of New Adult Positive Cases

	St. Catharines	Niagara Falls	Welland	Port Colborne
Far Advanced	20%	27%	34%	75%
Moderately Advanced..	25%	33%	66%	25%
Incipient	55%	35%	0%	0%

Dr. Alexander of the Brant Sanatorium, Brantford, writes:

"To supplement these figures and to possibly give a more direct estimate of the conditions from the year 1917 to the year 1922 inclusive, 352 cases of tuberculosis were under treatment and 69 of these died. From the year 1924 to the year 1929 inclusive, 595 cases of tuberculosis received treatment and of this number 37 died."

It will be agreed that the above statements of the condition of patients admitted from the same area before chest diagnostic clinics were being operated by the sanatoria, and afterward, show conclusively a most helpful influence resulting from their conduct, so far as the public welfare is concerned.

Florence Nightingale

Her influence upon the Soldiers of the Crimea and the World at large

By AGNES TENNANT, Preliminary Student, Montreal General Hospital.

Even as a child, perhaps unconsciously, Florence Nightingale was interested in the sick. Her diary and some of her letters record in detail the illnesses in her family or among the people on her father's estate. She loved to visit the sick with her aunt, and seems to have known them all intimately. She disliked the fashionable society life that was expected of her, and when she was still very young she dismayed her parents by expressing a desire to become a nurse.

The nurses of Florence Nightingale's time were very different from those of today. They were, for the most part, untrained, unscrupulous women and it is little wonder that Florence's people disapproved so heartily of her intention. But Miss Nightingale had a much higher ideal of nursing than anyone had hitherto dreamed of. In spite of opposition, she struggled and worked and planned. She read extensively, worked in London's ragged schools and work-houses, and studied the slums in cities abroad. She spent over three months in a nursing institution at Kaiserswerth, and the experience gained there formed the foundation of all her future actions. She brushed every barrier aside. Finally her parents allowed her to become superintendent of a charitable home in Harley Street. She had been there only one year when the Crimean War broke out. Her opportunity to serve had come.

Florence Nightingale was prepared. She realised to some extent the disorganisation of the Army Medical Department and the extreme need of the soldiers. She was equipped as no other woman of her time. Not only had she youth, freedom and training, but she had the support of the public and also of Sidney Herbert at the

War Office. She had ample material resources. She was desirous to serve and accustomed to command.

Miss Nightingale arrived at Scutari on November 4th, 1854. She found herself in the midst of what to us would seem hopeless conditions. "Want, neglect, confusion, misery—in every shape and in every degree of intensity—filled the endless corridors and the vast apartments of the barrack-house." Open sewers and cess-pools lay about the hospital, the floors were too rotten to clean, the walls were covered with dirt inches thick, vermin infested the buildings, and Miss Nightingale herself, who had visited practically every slum district in Europe, said that the stench was absolutely indescribable. There was practically no equipment. The cooking arrangements and the laundry were a farce. Medical supplies were all lacking. To struggle against these adverse conditions there was a mere handful of incompetent over-worked men. "There were moments, there were places, in the Barrack Hospital at Scutari, where the strongest hand was struck with trembling, and the boldest eye would turn away its gaze." Florence Nightingale and a handful of twenty or so nurses were expected to cope with these conditions. To make matters worse, most of the surgeons were hostile and suspicious. She was a woman and a pioneer and her position was a difficult one.

Miss Nightingale possessed a great deal of good-will and ability and the doctors soon began to realise this. Because of resources placed at her disposal by friends, she was able to supply some of the necessities immediately. Towels, soap, knives and forks, and tooth-brushes were provided. She completely reorganised the kitchens and laundries. Meals

were served punctually, well-cooked and appetising, and clean laundry was known for the first time. She even provided clothing for the patients. When news came that five hundred more wounded were to arrive, she herself superintended the remodelling of an old building because no one else thought it could be done. Late every night she sat in her office and wrote letters to the friends and relatives of the soldiers and also a lengthy one to Sidney Herbert, in which she poured out her hopes, difficulties and triumphs. She supervised all the nurses and military hospitals in the Crimea. Besides this she encouraged the soldiers to save their money, provided savings banks, and spent long hours in bookkeeping for them. It would seem that these duties would more than occupy any one person's time, but Florence Nightingale endeared herself to the soldiers and to the whole world by her attitude toward the suffering. She was busy, but where suffering was worst or encouragement needed, there, as if by magic, she appeared. Her equanimity, her sympathy, her gentleness and her dignity made her beloved of each soldier.

Miss Nightingale returned to England ill. She was ill for practically the rest of her life, and yet, during her illness, she devoted all her energy and devotion to work which has become immortal. She was haunted by a picture of disorganised military hospitals. Her work at Scutari had given her knowledge, power and reputation. She felt that the most urgent and obvious task was to look to the health of the army. She obtained the support of Queen Victoria, Sidney Herbert, and others in authority, but always she had to combat opposition from those who were obstinate and short-sighted. She finally succeeded in having a Royal Commission appointed to report upon the health of the army and then, much later, 1859-61, the actual reforms for which she had longed were

introduced. The barrack hospitals were remodelled. They were properly ventilated, warmed and lighted. The water supply was modernised, and kitchens installed where it was possible to cook. The purveyor's duties were accurately defined. The medical statistics of the army were reorganised, an Army Medical School established, and the Army Medical Department organised in such a way as to look after both the health and sickness of the soldiers. Miss Nightingale also tried to reform the War Office. This she never accomplished, but she saw that a Sanitary Commission in India investigated conditions there.

At the same time she was beginning to bring her knowledge, influence and activity into the service of the country at large. In 1859 she completed "Notes on Hospitals," which revolutionised the theory of hospital construction and management. "Advice flowed unceasingly and in all directions, so that there is no great hospital today which does not bear upon it the impress of her mind." Nor was this all. With the opening of the Nightingale Training School for Nurses at St. Thomas's Hospital in 1860, she became the founder of modern nursing. This involved initiative, control, responsibility and combat. Later on she carried out more general reforms in infirmaries and work-houses.

Florence Nightingale worked when the doctors said it would kill her if she went on. She seemed indefatigable, but it was her enthusiasm and mania for reform that made her work possible. Her foresight produced modern nursing, and the world, especially the nursing world, owes more than it will ever realise to Florence Nightingale. Her example is an inspiration to us, not only to live up to her ideals, but, even though we cannot succeed in the measure that she did, to try to advance nursing science and art as she tried.

(Reference: "Eminent Victorians," by Lytton Strachey.)

Department of Nursing Education

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A Suggested Plan of Health Service for a Hospital and School of Nursing Personnel

By MARION LINDEBURGH, Assistant Director, Teaching in Schools of Nursing,
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The formulation of a health service programme for a hospital and school of nursing personnel is one of theory, rather than in relation to any existing programme which could be taken as a basis for analysis, and evaluation.

Certain recognised hospitals have established some type of health service for their employees, but largely in the nature of care during illness rather than as a programme of prevention and health promotion. The positive aspects of health are receiving the major emphasis in all well-functioning community health organisations today, but the hospital seems to have lagged behind in assuming responsibility in regard to these wider implications of a modern health service for its working members.

In the last fifteen or twenty years the health of the worker has become recognised as a very important factor in the promotion of national prosperity, and this has been strongly reflected in the industrial field. Statistical reports indicate a high correlation between the health of the worker and increased production, and it is reasonable to assume that this economic value is the major objective in the organisation of a health service in any industrial institution. The relationship between health and production has become so well recognised, that there has been a greater advance in health maintenance in industry than in any other field during the same period of time. Such an appraisal does not mean to suggest a total indifference on the part of employers in other fields, but it does suggest that much more can be done in improving the type and the scope

of service which exists in many institutions at the present time.

The new conception of the term "hospital" as a health motivating agency cannot fully merit such function unless it extends its health facilities to those members of its community who work within its walls. With medical and nursing facilities so easily available the hospital should surely demonstrate a type of health service at least equal to any recognised health service which exists in other community institutions.

It is not the purpose in this brief proposal to go into details of the smaller and more technical administrative adjustments which naturally would vary in pattern in different situations, but rather to suggest a general plan of organisation and function to serve as a working basis.

The successful function of any department can be thought of in terms of its centralisation and the efficiency and co-operation of its personnel. Such criteria can be equally applied to the organisation and function of any health service. Therefore, in function, one might think of a centralised office under the direction of a competent head, and with a service so planned as to take care of all members within a hospital organisation. However, in actual analysis it may seem advisable and more expedient to separate the health service for student nurses from that for other hospital departments. This suggestion is made not only because in so many instances the nurses' residence is a separate unit, and removed somewhat from the main hospital building, but because the school of nursing, although a de-

partment of the hospital, is in itself an educational institution, and is therefore demanding of a student health service similar in character to the type which is being maintained in many academic and professional schools at the present time.

In the hospital proper, the service should be organised to provide for systematic examination, and to meet the daily health needs of all employees in the several departments. In suggesting the best organisation to meet this situation certain specific factors should be considered: firstly, the extent and nature of the service; secondly, the type and number of personnel; and thirdly, adequate office facilities.

The initial health examination of every new member employed should be imperative. It has been the practice in many fields of employment, and a somewhat universal practice in certain professional schools that the applicant present a certificate of health signed by the family physician. Such a procedure has not, up to the present, been satisfactory. To a very large extent this has been more or less a formality on the part of both the physician and the applicant—another "form" which must be filled out and signed to meet the request of authorities. This apparent lack of co-operation can be explained by the fact that the medical profession as a body, as well as the nursing profession and other intelligent groups, have not as yet the fullest appreciation of the place and significance of the health examination as a determining factor in the personal qualifications of all individuals in service. A request for an examination by any person in apparent good health should be given as serious consideration, and should be as thoroughly performed as one relating to a diagnosis of the sick. This elaboration is merely to emphasize a principle, that a health service should provide for the initial examination of all applicants rather than that any

statement from without should be accepted.

The main features of a health examination, as determined by the physician, might be covered under the following headings:

1. Weight in relation to nutrition standards.
2. Examination of heart and lungs.
3. Examination of nose and throat.
4. Test of vision and hearing.
5. Dental inspection, with particular attention to condition of gums.
6. Blood count.
7. Urinalysis.
8. Immunisation—smallpox and typhoid.
9. Postural defects—spinal curvature, flat feet, chest expansion.
10. Habits of living—having a direct bearing on health.

Emphasis of certain aspects of this examination may vary in relation to the department in which the applicant is to be placed: that is, a physical disability might totally disqualify an applicant for one department but not for another. This decision should be made by the examining physician in agreement with the head of the department concerned. The point might be made here, that should the hospital agree to accept an applicant with a constitutional defect, it will not be expected to care for that employee indefinitely, should the condition unfit the individual for work while employed by the hospital. As to whether all applicants should have a Wasserman test would be a question for those in authority to decide; suspicious cases should be checked, and all food handlers should be given a rigid examination and subjected to more direct supervision.

It is worthy of mention that a certain period of hospitalisation time is granted employees in many hospitals, with salary, and some type of contributory "sick benefit" which provides for longer periods of illness is as valuable a provision in hospital institutions as it is proving to be in many commercial and industrial firms.

A periodic health examination should be provided at least once a

year. This differs in purpose from the "inspection" character of the initial examination in that it should be in the nature of "supervision." It should be considered as a method whereby the individual's health status could be noted from time to time.

The second general consideration as above suggested is "personnel." The nature of the health examination demands the services of a member of the resident medical staff. Who should contribute this service, and the most efficient plan of organisation throughout the year, could best be decided by the superintendent in conference with the head of the medical staff. It would seem that daily complaints of employees could be cared for in the Out-Patient Department, but here there are opposing economic factors to be considered. By this method the service of the doctor would be conserved for regular hospital responsibilities, but the time it would take for the employee to go through the clinic would mean time away from his work and an economic loss to the hospital. However, in small hospitals the plan would be suitable. The physician might need an assistant during the time periodic health examination is undertaken; it would depend upon the amount of time he could give to the service and his plan of organisation for accomplishing these examinations during the year. In any case, a nurse would be needed in this service. She could take the family history, record weight, and do the tests for vision and hearing, if the ordinary objective tests as undertaken by nurses in school health work and other public health fields are used. In some services the nurse also undertakes the dental examination, referring suspicious cases of pyorrhoea or other signs of focal infection to the doctor. However, when there is a physician in charge it would seem advisable that he should undertake the examination, the nurse doing the "follow up," where correction of the defect or some treatment is advised by the doctor.

The third consideration is office facilities. The location of the health office should be so planned as to be most accessible to, and in close contact with, essential clinical facilities. For instance, scales might not have to be purchased if those of an adjacent department could be used. On the other hand, if they are provided within the health office, all members can be encouraged to record their weights frequently as an index to health. Three small rooms would be most adequate, consisting of a waiting room, office, and dressing room. However, less space need not handicap the quality of service to any great extent.

Health records for each individual should be kept up to date. Space on the card should be allotted to record social and medical history, a detailed account of the health examinations, visits to the health office, the difficulty and the treatment.

Dr. Wood, of Columbia University, who is considered a great pioneer in Health Education, and who was one of the early advocates for health examination and organised health programmes, suggests that individual and community health is bound up in three major provisions: namely, health examinations, healthful surroundings and health education.

Such criteria might well apply to any efficient health service. In this treatment the first essential has received its emphasis, and some space must be given to a brief consideration of the other two suggestive factors.

In view of the fact that many a large percentage of the hospital personnel live within the institution, consideration should be given to making their surroundings as conducive to health and happiness as is possible. The traditional idea of placing the "Maids" quarters in a part of the building (often the basement), ill suited for anything else, does not suggest sufficient personal interest in the worker. Favourable conditions of air, sunshine, and adequate toilet and bathing facilities should be minimum

essentials. Rest rooms are particularly recommended for off-duty hours and relaxation during the lunch hour.

Food service is an important health factor, affecting every one in the hospital's employment. Frank E. Chapman, in his book "Hospital Organisation and Operation," states, "in no time should the problem of the dietary department in satisfying the tastes of the personnel be belittled. In an institution which is a home to a larger proportion of the personnel there is no opportunity to cater to individual likes and dislikes, therefore there is a large proportion of dissatisfaction." The author discusses the problem of individual "tastes" and suggests a cafeteria service as a possible solution. In viewing the problem from a "health" point of view one can see certain difficulties ahead in attempting to impose an adequate diet, which may be contrary to "tastes," nevertheless in the final analysis the fundamental basis upon which a food service should be organised should be in relation to health requirements, whether for the sick or the well. The cafeteria plan or some modification of it, whereby a certain menu could be maintained, at the same time affording some choice, would be an improvement on the "service" system where much food is wasted because of no opportunity in a choice of meats, vegetables or fruits. Such a plan should of course be under the scientific direction of a qualified dietitian.

Health education, as the third provision of an adequate service, suggests some type of incidental or systematic instruction. Just how a teaching programme could be most fittingly incorporated into a hospital health service is a problem deserving of liberal consideration. The main objective of such a programme would be the development of a health conscience, involving responsibility to self and others; for instance, an individual in reporting a symptom of illness to the health office should do so in the realisation of the fact that he owes this

attention to himself, and that he is safeguarding the health and welfare of others. Experience has shown that in the health control of a large body of students where health instruction was given early in the term, emphasizing personal and social responsibilities and setting forth a plan of procedure in co-operation with the health office, that communicable disease could be reduced to a mere minimum by the conscientious reporting on the part of the students of possible "exposures." It means in many instances the exclusion of one or more students for the particular period of incubation, but it conserved the attendance and health of the school as a whole. Mention is made of an actual situation only to prove and to emphasize by a concrete illustration, the effect of instruction in the development of desirable health attitudes, among any group of people.

The doctor and the nurse in the health service should take every opportunity to give purposeful health instruction during the office visit. The "follow up" function of the nurse affords friendly contacts, and further opportunity for giving the specific type of instruction best suited to individual needs.

Printed health materials can be prepared and circulated to stimulate interest, to improve health practice, and to promote co-operation. The small pamphlet or poster type of material is desirable—avoiding the use of any lengthy exposition which provokes the reaction "not time enough to read." The following is a copy of a small poster that is distributed by a particular health service for the benefit of residents:

"HEALTH SERVICE"

"This service is for you."

"Do not neglect to come if you are concerned about your health."

"You owe it to yourself"

"You owe it to others."

"Our service will assist in

Preventing illness

Promoting your health."

Another suggestion of a different type of psychological appeal is as follows (an analysis chart to stimulate interest in personal health):

"What is my health worth to me?"

"What would added years of earning power be worth to me?"

"What advice did the doctor and nurse give me at my last health examination?"

"Did I carry out the instruction?"

"When did I have my last dental examination?"

"Did I carry out advice?"

"How much less has it cost me for dental repair this year?"

"When do I intend to have another dental examination?"

"In what respects have I improved my health?"

"In what respects have I helped others?"

Perhaps there is no other department where the need of a "health conscience" and favourable health practice is so essential as in the dietary department. Members of the kitchen staff, who are preparing food for others, should maintain certain standards of personal health practice which will safeguard the health of others. A vivid recollection is of a

kitchen chef who habitually blew his nose on his apron, without any conception of the extent to which he had violated the laws of health. One refrains from thinking of the multitude of non-intelligent individuals, with no appreciation of health values, who are busily engaged in the preparing of food. The dietitian, because of her close contact with the kitchen workers, and her special and scientific education, seems to be the appropriate person to undertake some form of incidental or systematised teaching.

The following "Don't" slogan, as planned for restaurant workers, is simple and appealing:

"Don't go into kitchen without clean hands and finger nails."

"Don't wipe hands on coat or trousers."

"Don't handle food with hands when fork or tongs can be used."

"Don't taste food while preparing it."

"Don't cough over food."

"Don't forget to wash hands after visiting toilet."

"Don't neglect these rules."

"Don't say 'I never read them'."

(Concluded in June number.)

Survey Report Studied

At the April meeting of the Montreal General Hospital Alumnae Association, to which all nurses in Montreal interested in the Survey Report were invited, Dr. A. T. Bazin delivered a most interesting paper, which covered the entire report. Stevenson Hall, in which the meeting was held, was packed to overflowing, it being estimated that approximately 400 registered nurses, representing all the English-speaking Nurses Alumnae Associations of Montreal, also several of the French-speaking groups, and many others, were present.

A very lengthy question-box period followed Dr. Bazin's marvellous paper, during which the entire group present participated.

Montreal nurses realise their good

fortune in having Dr. Bazin to help and advise them on many points concerning their service to the community, but his method of clarifying the high lights of the Survey Report, his sympathetic understanding of the problems confronting the nursing profession at the present time, and his belief in better education of all nurses proves the nurses' stronghold of defence against destructive criticism, for he can show them in his own inimitable way where their duty lies, and will assist them to carry on and aspire to greater things. — E. F. UPTON, President, Montreal General Hospital Alumnae Association.

[EDITOR'S NOTE: Copy of Dr. Bazin's paper was received too late for publication in this issue. It will appear in the June number.]

Department of Private Duty Nursing

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An Outsider's Reflections on Nursing

By EDITH A. DAVIS, North Sydney, N.S.

Like most other things in this strange and interesting world, nursing falls into three classifications: the good, the bad and the indifferent. But beyond these distinctions, the existence of which any experienced person will admit, there are the professional and the home-made varieties, and it is with nursing as it falls into these orders that this article has to do.

This is a day of specialising, and every trade and profession has its efficiency experts. To this rule nursing is no exception, and nurses, although they must be born as such, are made also. Every hospital has its training school, which yearly turns out a class of registered sick-bed attendants, armed with diplomas and vested with caps of authority and prepared to go about the world taking temperatures, making beds and shaking bottles, and qualified to cut and slash according to the latest prescribed methods. These graduates know what to do upon entering the sick room and how to do it. Their spotless, rustling uniforms—yea, even the smell of starch—fill their patients with awe and themselves with confidence.

The manner in which healthy young people devote themselves to the care of the sick, the suffering and the helplessly afflicted is one of the finest things in human nature. Truly Florence Nightingale lit a lamp whose rays reflect light and glory upon our world. To usher citizens into the world, and out of it, and to care for them during the interim through "all the ills that flesh is heir to," is an occupation which requires skill, special training, and, more than either of these, good, solid everyday common-sense and kindliness.

The nurse who spends her time within the walls of an institution has much in her favour, for there she finds system, cleanliness, and the proper things to work with. Not so with her sister of the "going-about" orders of her profession. Into the depths of the slums she penetrates, and, going from house to house, she deals with people of every race, colour and character. She confronts Life in all its aspects, and meets many odours, not necessarily of sanctity. Through every kind of weather she cheerfully makes her way to her various destinations, seeing in any given day the good and evil of human composition, and confronting situations ranging from the tragic to the ridiculous. Up crooked streets, into back alleys, as well as to the houses of the better-to-do she carries her healing and soothing powers. It is the nurse's tragedy that she deals only with sick people and upset households.

Closely allied to the trained nurse, yet in many ways far removed, is the home-made article. She is unregistered, and a member of nothing but a family or neighbourhood. She is called upon at a moment's notice to step into the breach and take care of sick relatives or friends. This is a decided disadvantage, because over such she has no authority. She is supposed to be a combination of Florence Nightingale and Cinderella. She generally works with all the modern inconveniences, and spends much time in walking around low, old-fashioned beds or improvising back-rests, air-cushions or bedside tables, without the proper materials. She may have all the work of the house to do, so that her day is one long succession of sandwichings.

To see a family through a seige of influenza, for instance, requires all the skill of mankind, the patience of saints, as well as the persistence for which the lower angels are noted. If it could only be arranged for the whole family to take to their beds at once, instead of succumbing one by one, it would be easier for the poor nurse, whose brains and hands must carry on two sets of activities. See her at the day's work. When she has lit the fire and fried the bacon and eggs for the family breakfast, she runs upstairs to get her patient washed and ready for the day. Downstairs again to prepare a dainty breakfast tray she may have encounters with the milkman, the grocer's boy, the laundryman and the postman. When she is halfway upstairs with the tray the telephone rings, and down she comes to inform somebody that they have the wrong number. The tray delivered at its destination, a spoon is found to be missing, and down she goes for the missing article. By the time the patient's room is set to rights the mind must suddenly switch itself to the family dinner arrangements. To this end the nurse must now make two desserts, one of hearty proportions and one of invalid-like lightness; while at it, perhaps, a little soup for the patient. By this time the dishes have accumulated, as is their wont, overflowing the table into the sink. However, they can always wait, and do. The coal-scuttle likely stands empty, so she decides to kill two birds with one trip to the basement and to take up the ashes at the same time. Once into the basement and wrestling with the powers of dirt and darkness, she begins to operate on the furnace and make a job of it. At this time the doctor arrives, and on the way to the front door she must transform herself from a fiend of the lower hell into a ministering angel!

In the sickroom she listens politely to the doctor's cheerful remarks, and memorizes his instructions carefully, wondering at the same time if he will

go before the things on the stove begin to boil over. He probably leaves two prescriptions to be filled out "right away," and she enters into a rapid-fire calculation with the clock and decides that it cannot be done before dinner.

There are times when the nurse feels worse than the patient, and when, in order to get around, she must get behind herself and push. However, on she goes, and, so strange a thing is human endurance, no matter what she feels like in body or mind, she generally has a joke ready for the sick one. The only minute she has to herself may come perhaps about midnight, when, the patient tucked in, the milk bottle put out, and all things smoothed away for the night, she sinks into bed for a few minutes' read before turning out her light. Sometimes she is too tired to go to sleep, but more often she wants to switch her mind to something on the funny side. And then (for she is never off duty) she goes to sleep with two ears up, in case of a call.

The hardest part of caring for members of one's own family is that one is more relative than nurse, and set on no particular pedestal. They realise that the nurse is only the same person as when they are well.

Now, whether a nurse be trained or home-made, there are some general rules which she must observe or her work will be of no avail. In the first place, she must consider her patient first and foremost, for to be kind and unselfish is the first tradition of nursing. If a nurse should glance into the mirror every time she passed on her way to the sick bed, or stop to powder her nose, she would not inspire the patient with any particular idea of confidence. Sick people need to be cheered up as much as anything, and when a nurse says, "Your temperature is a little higher this morning. Oh! I hope I didn't frighten you!" she has delayed the cure.

Commonsense is an essential above all things. If a woman has saved up

for ten years to buy an expensive dressing-table her temperature will jump, along with her temper, if, when she is ill, someone stands a dripping glass or a cup of hot beef tea on it. If a patient has no appetite it may be coaxed along with a dainty bowl of soup, but never with a quart of fish chowder.

Another excellent thing in nurses is an attitude of professional secrecy regarding their cases. People either do not wish their symptoms discussed at all or they want the pleasure of doing it themselves.

If sick people want a thing they want it without fuss, and then they generally want to be left alone. It is not good to be always changing sheets and sponging the face, when the patient wants rest or perhaps a good cup of tea. A sense of cheerful repose is greatly to be desired in a sick room, and this cannot be obtained where there are continual goings-on. Rest

is above all, for it is often want of it that has sent the patient to bed. "Save the strength to fight the fever" is a wise doctor's watchword.

The reward of nursing is not in the salary altogether, for, as a great writer has said, "To have done anything by which we have earned money merely is to have been idle and worse." The extra little acts of cheer and kindness are what make the nurse successful beyond the confines of remuneration. It is indeed a satisfaction to feel that it has come one's way to help to cure the sick, to ease the way of the afflicted, or even, putting it in Kingsley's homely way, to "help lame dogs over stiles."

All honour to all nurses, who, in every variety of circumstances, go about the world, each holding aloft her little lamp of healing, the rays of which reflect the light which Florence Nightingale started, and which shall not go out while civilisation lasts.

The History of Nursing Society, Montreal

The History of Nursing Society of Montreal held a meeting at the Montreal General Hospital on Monday, April 4, 1932. The Society was fortunate to have present, Dr. Maude Abbott, Lecturer in History of Nursing, School for Graduate Nurses, McGill University. Dr. Abbott still continues to show a deep interest in the work of the Society.

The programme was both interesting and instructive. A letter, written by Florence Nightingale, in pencil, to Dr. Campbell, of the Montreal General Hospital, was read and exhibited by Dr. Abbott. In this letter Miss Nightingale expressed her interest in Miss Machin, one of her graduates then at the Montreal General Hospital. This letter was written in 1876.

A short but interesting paper on the History of the Hospital of Notre Dame in Montreal was read by Miss Frances Upton.

The School of Hygiene of the Uni-

versity of Montreal has taken for its patron saint, St. Elizabeth of Hungary. Mlle. Martin, student at the School of Hygiene, read a paper on her life.

Mrs. De Hueck, student in the School of Nursing, Montreal General Hospital, delivered a short talk on "Nursing in Russia." This proved exceptionally interesting as Mrs. De Hueck gave her own personal observations.

Further papers were: "The Story of St. Ida," by Miss LeCompte, and the History of the Children's Memorial Hospital, Montreal, by Miss E. Hillyard.

The Society has collected considerable material on nursing during the course of its existence in Canada. It is to be found in the Medical Library at McGill University, and should be distinctly useful for the compiling of a book on History of Nursing in Canada.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,

MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

Public Health in New Brunswick

An encouraging report of development in the Department of Public Health in the province of New Brunswick for 1931 was presented recently to the Legislature.

In part, the report states that "The death rate from tuberculosis was the lowest in the history of the province; not one case of smallpox was reported by the health officers; diphtheria showed a slight decline; typhoid figures were the best in the history of New Brunswick; scarlet fever showed a marked decline in cases and death rate; but three deaths were attributable to infantile paralysis, and infantile mortality was the lowest ever recorded in the province."

Tuberculosis: The decreased mortality rate from tuberculosis is probably due to the cumulative efforts of the past decade. The segregation of "open" or infectious cases in institutions, the finding of early cases through the diagnostic service, the education of the public through this service and also through the nursing services, the general improvement in health of school children through the medical inspection of schools—all these are beginning to bear their fruit.

Diphtheria: There was a very slight decline in the number of cases, with total deaths from diphtheria, in 1931 when compared with 1930. This disease has throughout the past few years increased both in frequency and severity throughout North America, and New Brunswick has

felt the effects of this "wave." Protection through the use of toxoid has been made available to all children. In the past three years approximately 43,000 children of school age and younger have been inoculated free of charge under the supervision of the Department of Health.

Typhoid Fever: The report stresses the need for greater sanitary control, particularly of water and milk supplies, of the urban and rural areas, as a comparison of death rates from typhoid showed that the rate for all towns was almost five times greater than that for the combined cities, while the rate for the purely rural area was more than twice that of the cities. For the fiscal year there were one hundred cases of typhoid with thirteen deaths, or a death rate of 3.1 per 100,000 population. These figures are the best on record for New Brunswick. The report points out that although much can be done by an efficient health department to limit typhoid after it occurs, yet such results are of far less value than efforts put forth toward making the occurrence of such outbreaks impossible.

Smallpox: During 1931 there was not a single case of smallpox in New Brunswick. The eradication of this loathsome disease may be attributed only to the general vaccination of school children, which has been made possible through the medical inspection of schools. In the past twelve years over one-quarter of the population of the province has been successfully vaccinated.

Statistics in the report show there were twenty less deaths from cancer than in 1930. Diseases of the heart continue to hold first place in causes of death, with pneumonia second and tuberculosis third.

The birth rate shows a slight increase over the past two years; total births registered were 10,534, or 24.9 per 1,000 population.

Medical Inspection in Schools: The number of pupils examined in 1931 exceeded that of 1930 by 17%, and a decided increase in the effort of parents to overcome defects reported in their children has been noted. Inspection was made in 250 more schools in 1931 than in 1930, and of the total defects found 50% were dental and 27% nutritional. The total free vaccinations were 27% greater than for the preceding period. Since the establishment of medical inspection in New Brunswick there have been almost 118,000 school children vaccinated.

Infant Welfare: There are five nurses in public health work in New Brunswick devoting their efforts almost entirely to infant welfare work.

including pre-natal, with a lesser amount of tuberculosis follow-up and some school nursing. The nature of this work is naturally educational, and with the limited funds at their disposal an effort has been made to apply this service where it is most urgently needed, i.e., where the infant mortality rate has been highest. Education of the mother as to proper care of her child and the best ways of avoiding those conditions which are inimical to its well-being, especially in its first two years, will eventually not only lessen the present altogether too large sacrifice of infant lives but will also lay a surer foundation for future health, which will be productive of a sturdier and happier population in years to come.

The generalised nursing service carried on by local health committees and the Victorian Order of Nurses is likewise producing a beneficial effect in furthering the education of young mothers. The tentative rate of infant mortality indicates the best record ever attained. Does anyone doubt the potential value of the programme of the Department of Health?

The Canadian Public Health Association

The twenty-first annual meeting of the Canadian Public Health Association will be held on May 25, 26, 27, 1932, in the Royal York Hotel, Toronto, Ontario.

The Public Health Nursing Section will hold a session on Friday morning, May 27th, commencing at 9 o'clock, when the following programme will be presented.

I. Summary of the Chapter on The Public Health Nurse, from the Survey of Nursing Education in Canada, by Miss M. Moag, Victorian Order of Nurses, Montreal, Quebec.

II. The Psychiatrist Looks at Public Health Nursing, by Dr. W. T. B. Mitchell, Director, Mental Hygiene Institute, Montreal, Quebec.

III. The Private Physician Looks at Public Health Nursing, by Dr. A. M. Jeffrey, Toronto, Ontario.

IV. The Public Look at Public Health Nursing, by Mrs. H. P. Plumptre, President, Toronto Branch, The Canadian Red Cross Society.

V. The Public Health Nurse Looks at Herself, by Miss B. E. Harris, Oshawa, Ontario.

On Friday afternoon, at 4.00 p.m., the Public Health Nursing Section of the C.P.H.A., in conjunction with The Community Health Association of Greater Toronto, will give a Tea at the Royal York Hotel, at which Dr. Haven Emerson will be a guest and speaker.

Reports of Annual Meetings

ALBERTA

The annual meeting of the Alberta Association of Registered Nurses was held on March 22 and 23, 1932, in the Masonic Hall, Edmonton. Miss McPhedran, president of the Association, opened the convention and about one hundred members were present. Delegates from Calgary, Lethbridge, Medicine Hat, and a large proportion of the schools of nursing in the province were represented.

President's Address: Miss McPhedran stressed the national importance of the Survey and indirectly the importance that it would be provincially. Among the things that Miss McPhedran touched on of provincial interest were the unemployment among nurses; the senate of the university regulations outlining the increased bed capacity to one hundred for schools of nursing in the province, also the establishment of an Inspection Committee for training schools. Alberta's approach in dealing with the inspection of training schools is slightly different to that of other provinces, recognising the fact that three factors exist in every school of nursing—medical, nursing and the laity. Therefore, a committee of three, representing these groups, has been appointed to make the inspection, whereas British Columbia, Ontario and Quebec have a nurse inspector for their schools of nursing.

The guest speaker, Miss Jean Browne, secretary of the Joint Study Committee of the Canadian Medical Association and the Canadian Nurses Association, addressed the convention twice and again at two separate luncheons, the subject of her addresses being the Weir Report. Her discussion on the Report was most interesting. She approached the Survey from many angles, and gave her audience a closer grasp of this

extensive piece of work done in connection with nursing education.

Dr. Barager, Commissioner of Mental Institutions and Director of Mental Health, and Miss C. Lynch, Superintendent of Nurses, Provincial Mental Hospital, Ponoka, discussed the Survey Report from their respective angles—Training Schools for Nurses in Mental Hospitals.

The future location of the National Office was discussed, and a resolution passed to the effect that the Association favoured the establishing of the National Office in Montreal.

Subscriptions to *The Canadian Nurse* and some way of increasing subscriptions from Alberta were dealt with.

A delegate was appointed to attend the C.N.A. general meeting in Saint John, N.B., June 21-25.

Committee Reports

The Public Health Committee reported that a special effort was being made to increase the subscriptions to *The Canadian Nurse* and that arrangements had been made for the purchasing of new books of interest to the Public Health Section.

The Private Duty Committee brought in a splendid report dealing with unemployment of nurses, and in conclusion described the Benefit Loan Fund which has been raised by subscriptions from nurses in permanent positions throughout the province. This fund is safeguarded by a committee whose duty it is to grant loans to nurses requiring aid under the present economic conditions.

There was a brief report from the Nursing Education Committee.

In Miss McPhedran's report from the senate of the University of Alberta, she stated that certain regulations governing the inspection of schools of nursing were submitted to the senate of the university and ap-

proved by them in December, 1931. An Inspection Committee was appointed by the senate of the university to conduct the inspection of schools of nursing, consisting of Miss Eleanor McPhedran, President of the A.A.R.N., and a member of the senate of the University of Alberta; Dr. J. J. Ower, Provincial Pathologist, and Professor A. E. Ottwell, Registrar of the University of Alberta. The selection of this committee represents the nursing group, the medical profession and the laity. It is expected that the committee will function very shortly.

The committee on the revision of the Registered Nurses Act and By-laws, presented several recommendations for changes and corrections in the present Registered Nurses Act which were approved by the convention.

It was decided that in future the annual meeting should be held in the spring of the year, rather than the autumn, as formerly.

ONTARIO

The annual meeting of the Registered Nurses Association of Ontario was held in Ottawa, March 31st, April 1 and 2. About 350 delegates registered, and the programme for the three days centred about a discussion of the Report of the Survey of Nursing Education in Canada from various angles.

On the first morning invocation was pronounced by the Reverend Channell G. Hepburn, and following addresses of welcome by His Worship, Mayor Allen, Reverend Father A. E. Armstrong and Dr. Warren S. Lyman, routine business of the opening session was conducted and reports of standing and special committees read.

An interesting report of the activities of the Council of Nursing Education was given by Miss E. MacPherson Dickson. Among the points stressed in the report were the following:

(1) Ontario has now an official list of approved schools of nursing.

(2) At the November, 1932, examinations only candidates from approved schools will be permitted to sit for the examination of registered nurse.

(3) Demonstration of nursing technique was made a failing subject at the November, 1931, examination.

(4) Records of the inspection of schools of nursing show a marked improvement in the preliminary educational standing of students presenting themselves for examination.

(5) Adequate staff for supervision of nursing care in student training has been provided by many hospitals in order to meet the requirements.

(6) Fourteen hospitals out of the fifteen 50-bed capacity class have discontinued their schools, and their students, then in training, were placed by the inspector of schools of nursing to continue elsewhere.

At the close of the afternoon a party was conducted through the Parliament Buildings by special permission and arrangement of Col. H. G. Coghill, Sergeant-at-Arms of the House of Commons. Pausing for a moment at the Nurses' Memorial, Miss Mary Millman, president of the Association, placed a wreath.

A banquet was held Thursday evening, at which the speaker was Dr. Stewart Cameron, of Peterboro, chairman of the Joint Study Committee on Nursing Education in Canada. Dr. Cameron's address was most thoughtful and stimulating, and gave in clear and interesting manner the historical background of the Survey and the implications of its findings. Dr. Cameron was introduced by Miss Elizabeth Smellie, Chief Superintendent of the Victorian Order of Nurses for Canada, and thanked on behalf of the Association by Miss Marjorie Buck, Superintendent of the Simcoe Hospital.

Friday was devoted in entirety to section meetings. At the Private Duty Section Dr. Stewart Cameron led discussion on the Survey as it relates to private duty nurses.

In the Public Health Section an interesting paper on "The Industrial Nurse in Relation to Public Health" was given by Miss Hazel Latimer, of the E. B. Eddy Company, Hull. Miss Latimer referred to her previous experience as a Victorian Order nurse being of considerable help to her in visualizing the home background of employees which was so necessary to adequate handling of the various problems encountered. Frequently the entrance of the nurse into industry was through the first aid room, but the work did not stop there by any means, Miss Latimer said. The nurse in industry was a teacher of health, charged with the responsibility of interpreting the laws of prevention in accident and illness among the employees.

A splendid paper on "The Advantages and Disadvantages of the Exchange System of Teachers" was given before the Nurse Education Section by Miss Helen Cowie, M.A., of the Ottawa Collegiate Institute staff.

At the afternoon session on Friday section meetings were continued as open meetings. In the Private Duty Section several papers were given. Miss Isabel MacIntosh, of Hamilton, summed up the chapter in the Survey on "The Private Duty Nurse." Chapters on "The Appraisal of the Patient," "The Nurse and the Public" and "Supply and Demand" were ably handled by Miss Jean Church, of Ottawa, while Miss Grace Mitchell, of Toronto, summarised the chapter on "Nursing Registries."

At the Public Health Section open meeting, Miss Edna Moore, Chief Public Health Nurse, Division of Child Hygiene and Public Health Nursing in the province of Ontario, gave an excellent and comprehensive summary of the section of the Survey dealing with public health and public health nursing.

At the close of the afternoon session Miss Gertrude Bennett, Superinten-

dent of Nurses of the Ottawa Civic Hospital, and her staff entertained at a delightful tea at the Nurses' Residence.

On Friday evening Professor W. C. Clark, director of the Department of Commerce and Administration, Queen's University, gave a thoroughly interesting resumé of "Current Economic Problems." Professor Clark spoke from a wealth of practical experience in the realm of economics, and had the happy knack of making his listeners feel thoroughly at home in his subject.

A unique feature of the evening's programme was the performance of the Ottawa Civic Hospital Glee Club. In daffodil coloured gowns with purple head bandeaux, the choir of forty voices presented a very pleasing appearance on the stage. Under the direction of Mrs. H. O. McCurry, with Mrs. Kenneth Meek at the piano, the musical numbers carefully selected and admirably executed, contributed in no small measure to the success of the evening.

Later a swimming party was held in the Chateau pool, followed by a reception in the Quebec Suite, at which the delegates were guests of the Ottawa graduate nurses.

At the final session held Saturday morning, Miss Christine Murray, instructor of nurses at the Ottawa Civic Hospital, gave a splendid comprehensive paper on "The Education of the Student Nurse." Asking the question whether or not our schools of nursing are to be factories for the production of skilled attendants, or educational centres for the production of young women of resourcefulness and initiative, Miss Murray said the answer rested with the training school. Miss Murray went on to outline the required curriculum recommended in the Survey of Nursing Education Report.

Summing up the various phases of the Survey which had been presented during the convention, Miss Jean I.

Gunn, Superintendent of Nurses, Toronto General Hospital, asked the question of her audience: "How long are we going to permit unrestricted production of nurses in the face of an overcrowded field?" Stating that practically everyone who has anything to sell requires a license, Miss Gunn said that early consideration should be given to the introduction into provincial legislation of a "practice act" which would license all who have nursing service to sell, who nurse "for hire," trained attendants and practical women as well as graduate nurses.

Miss Gunn submitted further that the high cost of illness and the inability of the average person to pay, foreshadowed some form of state medicine, group or hourly nursing as partial solutions.

Dr. Helen MacMurchy who was in the audience spoke briefly, congratulating the Registered Nurses Association of Ontario on the excellence of its convention programme, and stating that the Department of Pensions and National Health was deeply interested in the problems of nursing and in the Survey which had marked an era in the progress of nursing in Canada.

The remainder of the morning was occupied with the hearing of reports, the election of officers and unfinished business.

Officers of the Association remain the same as for last year: President, Miss Mary Millman, Toronto; first vice-president, Miss Marjorie Buck, Simcoe; second vice-president, Miss Priscilla Campbell, Chatham; secretary-treasurer, Miss Matilda Fitzgerald.

SASKATCHEWAN

One hundred and four nurses registered at the fifteenth annual meeting of the Saskatchewan Registered Nurses Association, which was held on March 31st and April 1st in Saska-

toon. On the first day meetings were held in the Nurses' Home of St. Paul's Hospital and in the Nurses' Home of the City Hospital on the second.

The President, Miss Elizabeth Smith, of the Normal School, Moose Jaw, was in the chair. Thursday morning, March 31st, was given over to a business meeting. Discussion of the Survey of Nursing Education in Canada occupied three sessions, also following a largely attended banquet on Thursday evening, Dr. F. M. Quance, Dean of Education, University of Saskatchewan, gave an outline of the Survey. Dr. Quance explained his review was informative and not critical.

Miss E. Smith, president, introducing the Survey Report, was followed by speakers who presented Survey findings relative to (a) the Private Duty Nurse, (b) the Institutional Nurse, (c) the Public Health Nurse. Each of the presentations was followed by discussion. At a later session other angles of the Survey presented and discussed related to (a) the Training School, (b) the Curriculum, (c) Nurse Registries. During the first hour of the final session Miss R. M. Simpson dealt with the Recommendations of the Survey. Other nurses who participated in presenting and discussing the Survey were: Mrs. Pendleton, Miss Munro, Miss Amas, Miss Gruhlke, and Sister Quinneville, of Saskatoon; Miss E. E. Graham, Miss Lynch, Miss H. Smith, of Regina; Sister Raphael and Miss Last, of Moose Jaw; Miss Montgomery, of Prince Albert, and Miss Lewis, of Weyburn.

Sections: Miss G. M. Watson, chairman of the Nursing Education Section, explained the inactivity of the section had been due to awaiting release of the Survey Report. In view of anticipated recommendations, members of the section had decided to await the Report before making plans for a definite campaign in nurs-

ing education interests in Saskatchewan.

Mrs. E. M. Feeney, chairman of the Public Health Section, was unable to be present. Her report, read by Miss R. M. Simpson, gave an excellent summary of the vast amount of public health work accomplished in the province, showing that the present economic conditions only increased the duties of those in charge of this phase of nursing—among activities mentioned were: baby clinics, home nursing classes, the clothing relief, the providing of milk to children on relief, the various nursing services in public, high and vocational schools, the V.O.N. service and the Red Cross.

The chairman of the Private Duty Section, Miss Laura Wilson, of Moose Jaw, dealt particularly with the subject of unemployment, especially among members of the section. From questionnaires sent to several provincial centres it was concluded that the cause of unemployment aside from the financial depression, was due to too many student nurses being admitted to hospitals. The report included the suggestion that only general hospitals of over 125 beds be allowed to continue schools of nursing.

Scholarship award: A very pleasing feature of the dinner meeting was the announcement of the award of the scholarship for 1932. Miss Kathleen Rowley, of Craik, Sask., was chosen from among thirteen candidates. Miss Rowley, who trained as a teacher before entering the School of Nursing, Vancouver General Hospital, has been a member of the nursing service, Department of Public Health of Saskatchewan, for several years. The scholarship is

\$500.00 and entitles the holder to a year's study at a university in either public health nursing or teaching and administration in schools of nursing.

Conclusions reached: The members present went on record (a) as approving the suggestion that schools of nursing be conducted only in general hospitals of not less than 75 beds exclusive of cots and bassinets, these hospitals to be properly equipped and staffed for the education of student nurses; (b) that hospitals be asked to employ more graduate nurses for general duty; (c) that all hospitals employ at least two duly qualified graduate nurses registered in the province, one of whom shall be the matron; (d) that an extension of the hourly nursing system be endorsed.

The meeting recorded a resolution expressing appreciation to Dr. G. M. Weir and members of the Joint Study Committee for the Survey Report.

Delegates appointed: Miss E. Smith, president, of Moose Jaw; Miss H. Smith, of Regina, and Miss M. Chisholm, of Saskatoon, were appointed to represent Saskatchewan at the Canadian Nurses Association General Meeting in Saint John.

Officers: President, Miss E. Smith (re-elected); first vice-president, Miss R. M. Simpson; second vice-president, Miss M. McGill; councilors: Sister Raphael and Miss G. M. Watson; secretary-treasurer and registrar, Miss E. E. Graham.

By courtesy of St. Paul's and the City Hospitals, the nurses were luncheon guests on Thursday and Friday respectively at these institutions. The annual meeting in 1933 will be held in Regina.

Employment for Nurses

MANITOBA

Organised effort to aid in relief of unemployment among nurses in Manitoba was begun early in 1931 when it was recognised there was lack of employment among members of the Manitoba Association of Registered Nurses, especially among those residing in Winnipeg. A committee of three members, appointed from the Board of Directors of the M.A.R.N., was delegated to inquire into the situation, then report and offer suggestions as to means for relief measures. Later the personnel of the committee was enlarged to include a representative from the three large hospitals in Winnipeg and the secretary of the M.A.R.N. As chairman, the latter was requested to investigate the circumstances of all nurses listed on the Central Registry and to write all hospitals with schools of nursing notifying them of the desire of the M.A.R.N. to help whenever the situation of distress among their graduates became more acute than these hospitals could relieve.

In January, 1932, the board of the M.A.R.N. voted the sum of \$2,000.00 to be set aside for use in aiding nurses who should be engaged to give nursing care to critically ill patients who otherwise could not have that care. The co-operation of the hospitals was sought and the plan is being satisfactorily operated under the following regulations:

1. The secretary of the Association investigates the circumstances in every instance.

2. Aid is given to those members whose homes are not in the province of Manitoba and whose earnings are less than \$20.00 per month.

3. Each approved case is given a certain number of days' work (up to but not exceeding \$63.00)—confirmation of time given must be made in

writing by the superintendent of nurses, after which a cheque is issued for the amount due.

4. Twenty-five per cent. of the total funds voted for relief purposes is set aside for the use of members non-resident in Winnipeg, if applied for before September, 1932. The remainder of the funds is allowed to provide employment for members resident in Winnipeg.

An encouraging feature is that the Unemployment Relief Committee reports, while hospitals in towns and rural districts admit a certain amount of hardship among nurses, there are few cases in such need as stipulated in the foregoing regulations.

The Alumnae Associations of the Winnipeg General Hospital and St. Boniface Hospital have been organised to aid their members. The former Alumnae created a fund to which graduates already employed contribute monthly. Within the past seven months fifty-one nurses have received remuneration for approximately 460 days' work. With few exceptions, the nurses have been appointed according to group nursing plan for ten days at a time. The arrangement has proved beneficial to critically ill patients who could not afford special nursing care, to the hospital and to the nurses. The hospital offers meals free or at a minimum cost to the nurses so engaged.

The Alumnae of St. Boniface Hospital created a fund into which graduates with permanent employment contribute monthly a percentage of salary; married members have contributed quite generously. The fund has been augmented by sums of money raised by personal effort of members. Where necessary, patients in public wards have been supplied with special nursing care, also, on recommendation of public health nurses, patients

in homes where special care was needed have been supplied with a nurse.

So far this Alumnae has been able to cope with distress among its members. For the future the Alumnae has assumed responsibility for cost of meals served to nurses employed at the hospital whose fees are met from this special fund.

NEW BRUNSWICK

Organised effort to relieve unemployment among nurses in New Brunswick has consisted in the Association of Registered Nurses sending a request to all hospitals, registries and organisations which employ nurses that as many as possible graduate nurses be employed; that nurses

registered in the province be given preference and that in employing nurses who are married only those be considered who are entirely dependent on nursing for their living. A number of the hospitals while wishing to co-operate are prevented from doing so by the lack of funds. The Saint John General Hospital has added seven nurses to the permanent graduate staff, while an average of fifteen graduates are being employed monthly for general duty.

Numbers of private duty nurses residing in their homes have given their places on the registries to those living in lodgings and in greater need. While this measure has become effective through no organised plan it is proving beneficial and is worthy of record.

Book Reviews

Foods In Health and Disease: by Lulu G. Graves; published by The Macmillan Company in Canada, Toronto. Price, \$3.95.

The author states that she has written this book hoping it will prove helpful to the housewife, parent, business man or woman, doctor, nurse, dietitian and teacher of Home Economics, or in fact anyone who is intelligently concerned with his or her health and the means of conserving it.

It is obvious that a volume of this size designed to interest so many, must be too general and contain too much unnecessary detail, to be of value to nurses or dietitians or any professional group.

The bibliographies at the end of each chapter are very complete and greatly enhance its value as a reference book.

The first two chapters deal with the classification of food elements and the function of food and food factors in the body. These subjects are discussed briefly but clearly and concisely. The following

eight chapters are filled with descriptions of vegetables, fruits, sugars, nuts, animal foods, fats, beverages and food accessories. Some of these are familiar, and well known; others are not. But it seems unnecessary to devote two pages to a discussion of the potato!

The chapter devoted to the preservation of foods is both interesting and instructive. It covers a subject on which very little information is available.

The nine chapters of the second section of the book are concerned with therapeutic diets. The author does not aim to discuss therapeutic diets in detail, as numerous books on this subject are available; her desire is to discuss briefly the diseases in which diet is a salient part of the treatment, giving the points which will enable the person without medical training to understand why the diets are prescribed.

For this reason the book is too elementary to be of much value to nurses, except from the point of view of the bibliographies.

J. E. P.

The Social and Ethical Significance of Nursing: by Annie W. Goodrich, Dean, Yale University School of Nursing; published by The Macmillan Company in Canada, Toronto. Price, \$3.95.

In this book which is a collection of addresses and papers delivered to various audiences over a period of twenty years, the reader is enabled to gain an appreciation of the aspirations and ideals of the leaders in the nursing profession, whose aim is to train the members of that profession in such a way that they shall become a vital force in the social and health movements of the times.

Coming to us from the pen of an author with the long and varied experience of Dean Goodrich, these addresses contain much that is of peculiar significance to Canadian nurses at the present time. Compare, for instance, such quotations as the following with some of the recommendations contained in the report of the Survey of Nursing Education in Canada:

"Never had a profession a greater opportunity for social service, but a great opportunity implies a heavy obligation. Young women desiring to become nurses must cease to feel that this is a vocation that can be taken up with the least possible output of time, education and money. Institutions must awaken to the fact that their obligation to the patients, the student nurse and the community, makes it impossible for them to carry the burden of the complete education of the nurse alone and they must be willing to tap other sources. . . . And the state should realise that it is expedient to provide opportunities for, and regulate the education of a body of workers that it employs so largely."

"The nurse plays no small part today in raising the standards of community health, but the value of her contribution would be immeasurably strengthened and widened through organisation that centralised the nursing service of the community and obtained state support of nursing education."

"We are, in truth, public servants, and the knowledge that we should bring to our service is too great, and our responsibility too wide, for us to longer allow the individual institution for the sick to determine what our professional preparation shall be."

The addresses are logically grouped under such topics as: The Nurse and Ethics; The Nurse and Education; The Nurse and the Hospital; The Nurse and the Community.

This book should be in the library of every school of nursing and should receive the thoughtful consideration of every nurse interested in the development of her profession.

M. S. F.

Principles and Practices in Public Health Nursing, including Cost Analysis 1932.

Prepared by the National Organisation for Public Health Nursing. Published by the Macmillan Co., New York; 122 pages. Price, \$1.75.

This is a handbook prepared by a committee of the National Organisation for Public Health Nursing, to be used in conjunction with two former publications of that organisation: the Board Members' Manual and the Manual of Public Health Nursing. The preparation of the handbook was undertaken by a committee including such well known authorities as Haven Emerson, M.D.; Mary S. Gardner, R.N., and Marguerite A. Wales, R.N. For assembling the content of Part 1, the reader is indebted to Ann Doyle, R.N.

The purport of the handbook is to assist those charged with the organisation, administration and supervision of public health nursing work, to determine (a) the accepted principles and practices in this field, (b) the cost of service if such standards are to be maintained.

Part 1 deals with the quality of approved public health nursing service. Twelve general principles are enunciated. Valuable chapters are devoted to the qualifications and salaries of professional personnel and to supervision, including the administrative and advisory types. Another outlines standards for an accepted educational programme with recommendations regarding pupil nurse affiliation. Consistent with the preventive point of view, a chapter is written on the health of the staff.

Part 2 gives consideration to methods for computing the cost of a visit. Its content has been determined by a recent study of a selected group of health organisations in the United States of America; their staffs varying from one to upwards of one hundred nurses. Certain general recommendations are made and a special computation considered. Forms for use in calculating such costs are shown. An appendix to Part 2 portrays selected tables, one of which indicates the percentage of field nurse's time spent in various activities.

Altogether the handbook offers a lucid, concise and analytical presentation of public health nursing principles and their application. The brevity of the book has necessitated a nice discrimination in the choice of material. Naturally the presentation is primarily that of problems as reflected in the United States although, in varying degrees, the content will prove applicable to other countries. The need of the book cannot be challenged and to those responsible for determining and guiding policies relating to standards and cost of service, its value is unquestioned.

F. H. M. E.

The Programme of the Biennial Meeting Canadian Nurses' Association

Saint John, New Brunswick, June 21-25, 1932

MONDAY, JUNE 20th

- 1.30 - 2.30 p.m. EXECUTIVE COMMITTEE MEETINGS: Nursing Education Section.
Private Duty Section.
Public Health Section.
- 2.30 - 5.00 p.m. EXECUTIVE COMMITTEE MEETING: Canadian Nurses' Association.

TUESDAY, JUNE 21st

Morning Session, 9.30 a.m.

- 8.30 - 9.30 a.m. Registration.
- 9.30-10.30 a.m. Call to Order.
INVOCATION: Rev. C. Gordon Lawrence, M.A., Rector of Trinity Church,
Saint John, N.B.
Reading of Minutes of last Biennial Meeting.
Report of Honorary Secretary.
Report of Honorary Treasurer.
Report of Executive Secretary.
Report of Editor and Business Manager, "The Canadian Nurse".
Correspondence.
- 10.30-12.00 a.m. Reports of Standing Committees, with discussion:
1. Publications Committee—Miss Florence H. M. Emory.
2. Arrangements Committee—Miss Margaret Murdoch.
3. Programme Committee—Miss Florence H. M. Emory.
Presentation of Resolutions from Executive Committee and Provincial
Associations.
Appointment of Resolutions Committee.
Appointment of Scrutineers, with instruction regarding ballots.
Appointment of Press Representatives.
Roll Call of Federated Associations.

Afternoon Session, 1.45 p.m.

- 1.45 - 3.15 p.m. Reports of Special Committees, with discussion:
1. Joint Study Committee, C.M.A. and C.N.A.—Miss Jean E. Browne.
2. History of Nursing—Miss E. Kathleen Russell.
3. Budget—Miss Ruby M. Simpson.
4. Completion of National Memorial—Miss Jean I. Gunn.
5. Red Cross Enrolment—Miss Jean E. Browne.
6. Registries—Miss Isobel MacIntosh.
7. Exchange of Nurses—Miss Jean E. Browne.
8. Crest—Miss Marjorie Dobie.
9. Membership Campaign—Miss Mary Millman.
10. Post-Convention Tours—Miss H. Dykeman.
- 3.15 - 3.35 p.m. Presidential Address—"Whither."
- 3.35-4.30 p.m. Provincial Reports, with discussion:
Alberta—Miss Eleanor McPhedran.
British Columbia—Miss M. P. Campbell.
Manitoba—Miss Jean Houston.
New Brunswick—Miss A. J. MacMaster.
Nova Scotia—Miss Margaret E. Mackenzie.
Ontario—Miss Mary Millman.
Prince Edward Island—Miss Lillian Pidgeon.
Quebec—Miss M. K. Holt.
Saskatchewan—Miss Elizabeth Smith.

Evening Session, 8.00 p.m.

- 8.00 p.m. OPEN MEETING. Chairman, Miss A. J. MacMaster, President, New
Brunswick Association of Registered Nurses.
- ADDRESSES OF WELCOME:
Hon. C. D. Richards, Premier of the Province of New Brunswick.
His Worship Mr. James W. Brittain, Mayor of Saint John.
J. Alex. M. Bell, M.D., President, New Brunswick Medical Society.
Miss A. J. MacMaster, President, New Brunswick Association of Regis-
tered Nurses.
- RESPONSE to Addresses of Welcome—Miss Florence H. M. Emory, Presid-
ent, Canadian Nurses' Association.
- ADDRESS: "The Public and the Survey Report"—The Hon. Vincent
Massey, P.C., LL.D.

WEDNESDAY, JUNE 22nd**Morning Session, 9.30 a.m.**

GENERAL SESSION—A Consideration of Selected Recommendations of the Survey Report.

GENERAL TOPIC: The Approved Training School.

- 9.30 - 9.50 a.m. Introduced by Miss E. Kathleen Russell, Director, Department of Public Health Nursing, University of Toronto, and Nurse Member of the Joint Study Committee, Survey of Nursing Education in Canada.
- 9.50-10.00 a.m. (1) "The Superintendent of Nurses and the Instructors, Nursing and Medical"—Miss M. K. Holt, Superintendent, School for Nurses, The Montreal General Hospital, Montreal, Que.
- 10.00-10.10 a.m. (2) "The Entrance Requirements"—Sister Ignatius, Superintendent, School for Nurses, Antigonish, N.S.
- 10.10-10.20 a.m. (3) "The Head Nurse: Hospital Facilities for Teaching; The Curriculum"—Miss G. L. Rowan, Superintendent, Grace Hospital, Toronto, Ont.
- 10.20-10.30 a.m. (4) "Concerning Registration Acts in Relation to the Training School"—Miss E. MacP. Dickson, Superintendent, School for Nurses, Toronto Hospital for Consumptives, Weston, Ont.
- 10.30-12.00 a.m. **GENERAL DISCUSSION:** Concluded by a general summary and the presentation of related resolutions by Miss E. Kathleen Russell.

Afternoon Session, 2.00 p.m.

GENERAL SESSION: A Consideration of Selected Recommendations of the Survey Report.

GENERAL TOPIC: "An Analysis of the Cost of Nursing Education".

Introduced by Miss Jean I. Gunn, Superintendent, School for Nurses, Toronto General Hospital, Toronto, and Nurse Member of the Joint Study Committee, Survey of Nursing Education in Canada.

- 2.20-2.30 p.m. 1. "The Cost of the Student Nurse to the Hospital"—Miss E. M. McKee, Superintendent, General Hospital, Brantford, Ont.
- 2.30-2.40 p.m. 2. "The Comparative Cost of the Student and the Graduate Nurse"—Miss G. M. Fairley, Superintendent, School for Nurses, Vancouver General Hospital, Vancouver, B.C.
- 2.40-2.50 p.m. 3. "The Budget System"—Miss M. F. Hersey, Superintendent, School for Nurses, Royal Victoria Hospital, Montreal, Que.
- 2.50-3.00 p.m. 4. "Financial Aid from Government for Nursing Education"—Miss E. Smith, Normal School, Moose Jaw, Sask.
- 3.00-4.30 p.m. **GENERAL DISCUSSION**—Concluded by a general summary and the presentation of related resolutions by Miss Jean I. Gunn.

Evening Session, 7.30 p.m.

7.30 p.m.

DINNER.

ADDRESS: "The Scientist and the Survey Report"—Professor Roy Fraser, Mount Allison University, Sackville, N.B.

THURSDAY, JUNE 23rd**Morning Session, 9.30 a.m.**

- 9.30-11.00 a.m. "The Canadian Nurse" and Related Matters.
1. Report of Committee appointed to study matters relating to the National Office and "The Canadian Nurse"—Miss M. F. Hersey.
2. A Consideration of the recommendations of the Executive Committee of the C.N.A. concerning:
- (a) Change of office of the C.N.A. from a Western to an Eastern centre.
 - (b) The appointment of an Editor for "The Canadian Nurse".
 - (c) Methods of Finance.
- 11.00-11.45 a.m. **Affiliated Organisations:**
- 1. The International Council of Nurses:
 - (a) The appointment of four official representatives (with alternatives) to the Congress, 1933.
 - (b) Plans for transportation with reports from provincial presidents concerning an approximate number who may attend the Congress.
 - 2. The National Council of Women of Canada.
 - 3. The Canadian Council on Child and Family Welfare.
- 11.45-12.00 a.m. **NEW BUSINESS.**

Afternoon Session, 2.00 p.m.

NURSING EDUCATION SECTION—Chairman, Miss Grace M. Fairley

- 2.00 - 3.15 p.m. Minutes of last meeting.
 Chairman's Address.
 Report of Secretary.
 Report of Treasurer.
 Correspondence.
 Reports of Committees.

Reports of Provincial Committees on Nursing Education:

Alberta—Miss Edna Auger.
 British Columbia—Miss Mabel F. Gray.
 Manitoba—Miss Margaret S. Fraser.
 New Brunswick—Sister Corinne Kerr.
 Nova Scotia—Miss Elizabeth O. R. Browne.
 Ontario—Miss Constance Brewster.
 Prince Edward Island—Miss Anna Mair.
 Quebec—Miss Flora A. George.
 Saskatchewan—Miss Gertrude M. Watson.

Appointment of Resolutions Committee.

Appointment of Scrutineers.

Appointment of Standing Committee on Curriculum.

3.15-4.30 p.m.

ROUND TABLE—Topic: "The Curriculum in Canadian Schools of Nursing, and Re-adjustment in the Educational Programme".

Introduced by the Convener of the Committee on Curriculum.

Speaker: Professor F. Clarke, McGill University, Montreal, Que.

PRIVATE DUTY NURSING SECTION—Chairman: Miss Isobel MacIntosh

2.00-4.00 p.m.

GENERAL TOPIC: Meeting the Public Need in Service:

1. "The Intelligence and Education of the Nurse-in-Training"—Miss Sara Matheson, Montreal, Que.
2. "The Professional Growth of the Graduate Nurse"—Miss A. McQuhae, Toronto, Ont.
3. "Hourly and Group Nursing"—Miss E. Frank, Victoria, B.C.
4. "A Physician's Viewpoint"—Dr. S. R. D. Hewitt, Superintendent, Saint John General Hospital, Saint John, N.B.

Discussion led by Miss Agnes Jamieson, Montreal, Que.

PUBLIC HEALTH NURSING SECTION—Chairman, Miss Margaret Moag

2.00-3.15 p.m.

Minutes of last meeting.

Chairman's Address.

Report of Secretary.

Report of Treasurer.

Correspondence.

Reports of Committees.

Reports of Provincial Committees on Public Health:

Alberta—Miss Blanche A. Emerson.
 British Columbia—Miss Margaret Kerr.
 Manitoba—Miss A. E. Wells.
 New Brunswick—Miss H. S. Dykeman.
 Nova Scotia—Miss A. Edith Fenton.
 Ontario—Miss Clara Vale.
 Prince Edward Island—Miss Mona Wilson.
 Quebec—Miss Marion Nash.
 Saskatchewan—Mrs. E. M. Feeney.

Appointment of Resolutions Committee.

Appointment of Scrutineers.

3.15-3.30 p.m.

TOPIC: "Implications of the Survey to Public Health Nursing"—Miss Eunice Dyke, Director, Division of Public Health Nursing, Department of Public Health, Toronto, Ont.

3.30-4.30 p.m.

General Discussion led by Miss E. L. Smellie, Chief Superintendent, Victorian Order of Nurses for Canada.

FRIDAY, JUNE 25th

Morning Session

NURSING EDUCATION SECTION—10.00 a.m.

Chairman, Miss Grace M. Fairley

10.00-12.00 a.m.

ROUND TABLE—Topic: "A Discussion of the Survey Report from the Educational Angle, dealing with recommendations affecting Training Schools".

Discussion introduced by Miss Marion Lindeburgh, Assistant Director, School for Graduate Nurses, McGill University, Montreal, Que.

Election of Officers.

Unfinished business.

PUBLIC HEALTH NURSING SECTION—9.30 a.m.

Chairman, Miss Margaret Moag

- 9.30-9.45 a.m. "The Education of the Public Health Nurse"—Miss Margaret Kerr, Assistant Director, Department of Nursing, University of British Columbia, Vancouver, B.C.
- 9.45-10.00 a.m. "Supervision of Public Health Nursing"—Miss Marion Nash, Educational Director, Victorian Order of Nurses, Montreal, Que.
- 10.00-10.15 a.m. "Supply and Demand"—Miss Esther Beith, Director, Child Welfare Association, Montreal, Que.
- 10.15-12.30 p.m. General Discussion.

PRIVATE DUTY NURSING SECTION—9.30 a.m.

Chairman, Miss Isobel MacIntosh

- 9.30-10.30 a.m. Reading of minutes of last meeting.
Chairman's Address.
Report of Secretary.
Report of Treasurer.
Correspondence.
Appointment of Resolutions Committee.
Reports of Standing Committees, with discussion:
Exhibits—Miss Jean Davidson, Brantford, Ont.
Publications—Miss Clara Brown, Toronto, Ont.
Reports of Special Committees, with discussion:
Registries—Miss Isobel MacIntosh, Hamilton, Ont.
Constitution and By-laws—Miss Clara Brown, Toronto, Ont.
Business arising out of Minutes, Reports and Correspondence.
- 10.30-12.30 p.m. Reports from Private Duty Committees of Provincial Associations, with emphasis upon certain recommendations of the Survey Report:
Alberta—
British Columbia—Miss E. Franks.
Manitoba—Miss M. Lang.
New Brunswick—Miss M. MacMullen.
Nova Scotia—Miss J. Trivett.
Ontario—Miss C. Brown.
Prince Edward Island—Miss M. Lowther.
Quebec—Miss S. Matheson.
Saskatchewan—Miss L. B. Wilson.
A Summary of Provincial Reports—Miss Jean L. Church, Ottawa, Ont.
General Discussion—Introduced by Dr. Stewart Cameron, Chairman, Joint Study Committee, Survey of Nursing Education in Canada.
New Business.
Election of Officers.

Afternoon Session, 2.00 p.m.

GENERAL SESSION—A Consideration of Selected Recommendations of the Survey Report.

GENERAL TOPIC: "The Distribution of Nursing Services".

- 2.00-2.20 p.m. Introduced by Miss Jean E. Browne, Director of Junior Red Cross for Canada and Nurse Member of the Joint Study Committee, Survey of Nursing Education in Canada.
- 2.20-2.35 p.m. 1. "Supply and Demand":
(a) The unemployment of nurses.
(b) The reduction of the supply of nurses.
(c) Increase in demand for nurses.
—Miss K. W. Ellis, Superintendent of School for Nurses, Winnipeg General Hospital, Winnipeg, Man.
- 2.35-2.45 p.m. 2. "Socialized Nursing"—Miss Eleanor McPhedran, Superintendent of Nursing, Central Alberta Sanatorium, Calgary, Alta.
- 2.45-2.55 p.m. 3. "Dominion Bureau of Nursing, Provincial Councils and Provincial Boards of Control, District Registries"—Miss A. J. MacMaster, Superintendent School for Nursing, Moncton, N.B.
- 2.55-4.30 p.m. General Discussion—Concluded by a general summary and the presentation of related resolutions, by Miss Jean E. Browne.

Evening Session, 8.00 p.m.

OPEN MEETING

Chairman, Miss Florence H. M. Emory, President, Canadian Nurses' Association

8.00 p.m.

ADDRESSES:

"The Medical and Nursing Professions and the Survey Report"—Dr. G. Stewart Cameron, Chairman, Joint Study Committee, Survey of Nursing Education in Canada.

"Life, Profession and School"—Professor F. Clarke, McGill University, Montreal, Que.

SATURDAY, JUNE 25th
Morning Session, 9.30 a.m.

- 9.30-10.15 a.m. Reports of Sections—Activities throughout the two-year period and findings of the sessions:
 (a) Nursing Education—Miss Grace M. Fairley.
 (b) Private Duty—Miss Isobel MacIntosh.
 (c) Public Health—Miss Margaret Moag.
- 10.15-10.30 a.m. Report of Resolutions Committee.
 10.30-11.30 a.m. Unfinished Business.
 11.30-12.00 a.m. Election of Officers.
 ADJOURNMENT.

SATURDAY, JUNE 25th

- 2.00 - 4.00 p.m. Meeting of Executive Committee, Canadian Nurses Association.

PROGRAMME OF ENTERTAINMENT

Tuesday, June 22nd

- 4.30 p.m. Afternoon Tea: Saint John Infirmary and Saint John Tuberculosis Hospital.

Wednesday, June 23rd

- 5.00 p.m. Afternoon Tea and Drive: Guests of the New Brunswick Department of Health.
 7.30 p.m. Banquet.

Thursday, June 24th

- 4.30 p.m. Sail on Saint John River with Beach Picnic: Guests of the New Brunswick Association of Registered Nurses.

Friday, June 25th

- 4.30 p.m. Afternoon Tea: Saint John General Hospital.

A perusal of the Programme for the General Meeting of the Canadian Nurses Association assures all who are arranging to attend that the members of the Programme Committee have planned with meticulous judgment for a week of concrete study of the Survey Report, as well as for discussion of the undertakings and problems which at present are the chief concern of the National Organisation. Don't forget the date—June 21-25, 1932—also that the management of the Admiral Beatty Hotel, convention headquarters, will appreciate early reservation for accommodation. Rates are: Single

room, without bath, \$3.00; double room, without bath, \$5.00; single room, with bath, \$4.00, \$4.50, \$5.00; double room, with bath, \$6.00, \$7.00, \$8.00 and \$9.00. Additional persons in room, separate bed, add \$2.00.

In previous issues of *The Journal* there have been published several articles relative to the attractiveness of the Maritime Provinces for holidaying. Miss H. Dykeman, Health Centre, Saint John, N.B., as convener of Post Convention Tours Committee, will be pleased to supply more definite information to requests made directly to her.

Evangeline's
 Well at
 Grand Pre, N.S.



—Courtesy, Canadian Pacific Railway.

News Notes

BRITISH COLUMBIA

GENERAL HOSPITAL, VANCOUVER: At the monthly meeting of the Alumnae Association, by a majority vote the members decided that Orientals should be admitted to membership. Since no Orientals have been trained at the General Hospital, none are eligible for the alumnae, but if the time comes when Orientals are enrolled, they will be accepted as full members on graduation. Dr. H. E. Young, provincial health officer; Dr. A. K. Haywood, superintendent of the hospital, and Mr. J. G. Deildal, premier of the B.C. Older Boys' Parliament, all favoured the proposal to admit Orientals to training. The growing scope of public health nursing is creating a demand for Oriental nurses, Dr. Young said, but there are other considerations as well. "There was a time twenty years ago," he said, "when most of the Orientals in British Columbia were of the coolie class. Today it is different. Most of the Orientals in this province are keen and active business men, competing with us in the commercial world, and they demand equality in treatment." He also pointed out that Canada must trade with the Orient, and that British Columbia should maintain a friendly attitude to the people across the Pacific. "If we are going to build a real Canada, we must think nationally," Dr. Haywood said. The future of British Columbia depends largely on friendly relations with the Orient. Dr. Haywood pointed out also that language is a serious barrier to white nurses, who in the course of public health work might come into contact with Orientals. He declared that the General Hospital, by virtue of its size and standing, should set the example in the acceptance of Orientals for training. Mr. Deildal explained that Orientals had been admitted to the Older Boys' Parliament and that this action had tended to break down prejudice.

The annual banquet of the Alumnae Association was held in the Georgian Club on February 16, 1932. Among the guests were: the Honorary President, Miss Grace Fairley; past and present presidents, Miss Joan Hardy and Mrs. Ernest Gillies; Mrs. Edwin Carder and Dr. and Mrs. W. B. Burnett. Regret was expressed for the absence of Miss Dean O'Connor, one of the first graduates, and Miss Helen Randal, Registrar for British Columbia. Dr. Burnett was the speaker of the evening. Bridge was enjoyed following the dinner, and over one hundred nurses were present. Much enjoyment was had by the presence of many of the graduates who are only met on an occasion of this kind.

The Alumnae were hostesses at tea following one of the afternoon meetings of the Refresher Course in Institutional Nursing held in February at the Vancouver General Hospital. Tea was served in the Hospital Auditorium. Miss Grace Fairley and Mrs. Ernest Gillies received the guests. Miss

Clark, superintendent of Nursing at the Royal Columbian Hospital, New Westminster, B.C., and Miss Olive Shore, Training School Office, Vancouver General Hospital, presided at the tea table while other members assisted in serving. Many nurses from all parts of the province were present.

Miss Frances Newman (1924), formerly assistant night supervisor at the Vancouver General Hospital, who has been absent from the city for some time back is in Vancouver, and is now doing special nursing. Miss Ruth Swanson (1927), who has been on general duty in Sir Henry Gray's Private Hospital in Montreal, has also returned to Vancouver, and is at present visiting her family in Kimberly. Miss Margaret McPhoe (1923), assistant superintendent at the Sir Henry Gray's Private Hospital in Montreal for the past three years, has returned to Vancouver, where her family resides, and is at present on the staff of the Vancouver General Hospital Out-Patients' Department Clinics.

JUBILEE HOSPITAL, VICTORIA: At the annual meeting of the Alumnae held on March 14th in the Nurses Home, the election of officers took place: Hon. Pres., Miss L. Mitchell; President, Miss E. Oliver; First Vice-President, Mrs. Chambers; Second Vice-President, Mrs. Carruthers; Secretary, Mrs. A. Dowell, 30 Howe St.; Assistant Secretary, Miss C. McKenzie; Treasurer, Miss E. Newman; Entertainment Committee, Miss I. Helgeson; Sick Nurses, Miss C. McKenzie; Bursary, Miss L. Mitchell and Mrs. Chambers. A donation of \$50.00 was given to the Hospital Campaign Fund, and various means of raising money were discussed. The annual dinner is to be held as usual for the re-union of all Alumnae members and as a means of entertaining the Graduating Class. Several recent graduates have taken positions in the Country Hospital, Shanghai, China: Miss Green (1930) and Miss D. Cuff (1931) are already at work, while Miss D. Hicks (1931), Miss J. Pearse (1930) and Miss I. Beck (1930) left on March 28th for Shanghai.

MANITOBA

BRANDON: The regular meeting of the Brandon Graduate Nurses Association was held on April 4th at the Residence, General Hospital. The entire evening was devoted to business matters of the organisation. Officers were elected for the coming year, \$36.00 was donated to welfare work, while the annual membership fee was reduced to \$2.00.

WINNIPEG: The Public Health Section of the Manitoba Association of Registered Nurses has arranged a special series of lectures which are being given in the University of Manitoba on April 11th, 27th, and May 9th. On the two former dates the respective speakers were: Dr. H. E. Popham

on Some Disorders of Infants, and Dr. L. Arthur on Preventive Obstetrics. Dr. H. M. Speechly's subject for May 9th is What Shall We Teach the Preadolescent? All graduate nurses and members of graduating classes are invited to attend.

The many friends of Miss Mildred Reid, Winnipeg General Hospital School of Nursing, 1924, and School for Graduate Nurses, McGill University, are pleased to learn of her convalescence following a critical illness. Miss Reid is at present a member of the staff at the Provincial Bacteriological Laboratory, where her duties in part are demonstrating bacteriology to the students of the Medical College. She also teaches the same subject to the students of the School of Nursing, Winnipeg General Hospital.

NEW BRUNSWICK

ST. STEPHEN: A well-attended meeting of the local chapter N.B.A.R.N. was held in Calais, Maine, Miss Bertha Gregory and Miss Edna Cochrane being hostesses. The routine business being transacted, a delightful social hour followed. Miss Maida Baskin is recovering from a surgical operation. A profitable food sale was held by the members of the Alumnae recently. Sympathy is extended to Miss Irene Sherrard in the death of her sister.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in April, 1932, were 910, fifty more than in March, 1932.

DISTRICT 1

WINDSOR: The Essex County Registered Nurses Association held a very delightful bridge party on April 4th at the Prince Edward Hotel. A large number were present and the evening a most successful one. The arrangements were convened by Miss Florence Shanahan and Miss Ann Harvey, and Miss Flossie Greenway was in charge of the musical programme. Proceeds are being used for charitable purposes.

Miss Zae Londeau, who attended the Registered Nurses Association of Ontario Convention, held in Ottawa, March 31st, April 1st and 2nd, as a delegate from Hotel Dieu Alumnae Association, brought back a very favourable report to be read at the next meeting of the Alumnae.

Rev. Mother Gauvin and Rev. Sister Theresa of Hotel Dieu Hospital attended the Conference of the Catholic Hospital Association held in Ottawa recently.

DISTRICT 2

BRANTFORD: Miss Jessie M. Wilson, Chairman, District No. 2 and No. 3, Registered Nurses Association of Ontario, was in Ottawa for the annual meeting of the Association. Miss Margaret Jamieson, Brantford, has accepted the position of superintendent at the Brampton Hospital. Mrs. F. McLean (Edna Clarke, Brantford General Hospital, 1926), Brampton, Ont., has been a patient in the Brantford General Hospital for several

weeks. She expects to return to her home shortly. Miss M. K. Griffiths and Miss Quillie were joint hostesses on April 4th to the Florence Nightingale Club. Mrs. J. N. Mitchell presided over the business meeting. Minutes of the previous meeting were read by Miss T. Dawson. Dr. Elizabeth Kitley, Department of Health, Ontario, has been in Brantford for some time. Miss Eleanor Wheeler and Miss Edna Squires, of the Department of Health, Ontario, are in Brantford in connection with the survey of Public Health being carried on throughout the Province. Dr. J. F. Phair, Chief of the Division of Child Welfare, Province of Ontario, was a recent visitor.

GENERAL HOSPITAL, GUELPH: The Alumnae Association entertained at a bridge, Thursday, March 17, 1932, for Miss Ashplant and Miss McQueen, the Victorian Order nurses who have recently taken charge of the Guelph District. Mrs. George Black, of Montreal, was a recent visitor in the city. Miss M. Bliss attended the Registered Nurses Association of Ontario meeting held in Ottawa recently.

SIMCOE: Miss M. Buck, Vice-President, Registered Nurses Association of Ontario, was a guest at the Chateau Laurier, Ottawa, attending the annual meeting of the Association. Miss Florence Guenther, Norfolk County Hospital, also attended the annual meeting of the R.N.A.O.

DISTRICT 4

HAMILTON: Dr. Alan Brown, well-known pediatrician of Toronto, was the guest speaker at a dinner held at the Scottish Rites Temple by the Child Welfare Division of the Public Health Department. Dr. Brown gave an extremely interesting and informative address on "Diseases of Children," confining his remarks to the preventable aspect of the subject, and the latest methods being used in waging war on the many illnesses which are classed amongst Preventable Diseases. Dr. O. A. Cannon presided.

The Alumnae Association of the Hamilton General Hospital, together with the many friends of Miss E. Rayside, Superintendent of Nurses, are delighted to welcome her back to her post of duty following her recent long illness.

DISTRICT 5

WOMEN'S COLLEGE HOSPITAL, TORONTO: The monthly meeting of the Alumnae met at 74 Grenville St. on March 14th. Owing to the unavoidable absence of the President, Miss Eleanor Clarke, the Second Vice-President, was in the chair. After the usual business a very interesting report was read from the Hoiryung Public Health Centre, Hoiryung, Korea, which Miss Jessie Whitlaw (1926) superintends. The report gives accounts of well-baby clinics, also pre-natal and post-natal work, mothers' club and home economics, which includes the teaching of caloric values, bread and cookie making, also physical instruction and health talks to girls, boys, and members of the Women's Bible

Institute. Aid is also given in religious teaching. Their newest venture is the medical social evangelism through the country; this reaches the pre-school children. They also teach modern agriculture. Their entire staff is composed of six workers, and in the dispensary 5,728 treatments have been given. Miss Roberts (1924) gave a very interesting and instructive talk on the Maternal Care Institute lectures held at the Toronto General Hospital for the Public Health Section of District 5. Miss Roberts referred especially to Professor Hendrie's most explicit and instructive answers which he so kindly gave to the numerous questions. Members of the Alumnae were very pleased to receive word from Miss Alberta Jennings, who arrived in Santos, South America, on March 5th, and was starting on a 1,000-mile motor trip to the Brazilian interior to carry on her profession along with missionary service.

GENERAL HOSPITAL, TORONTO: The Alumnae held a general meeting in the Residence on April 6th, which a large number of members attended. It was decided to give a scholarship for \$400.00 to an alumnae member for a year's post-graduate work in Nursing in a Canadian university. Miss Dix reported that 415 members had applied for insurance in the Group Insurance plan. All who propose to apply for this insurance must do so before May 1st and must be a paid-up member of the Alumnae. Miss Moburn was nominated as Convener of a committee on the entertainment of the graduating class. Miss Strachan gave a most interesting report of the R.N.A.O. convention held in Ottawa recently. Miss Gunn presented a very analytical report on the findings of the Survey compiled by Dr. Weir. After a very comprehensive resume of the Report a direct appeal was made to alumnae members to study thoroughly the problems presented and as a result the executive was empowered to appoint a special study committee. Miss Manning presided at the meeting. Miss Eugenie Stewart demonstrated the use of the "Lister Spray" as a disinfecting appliance as used by Lord Lister in the 19th century. Miss Locke and Miss Kelley presided at the tables at the reception which followed the meeting.

Rev. and Mrs. Batstone (Constance Parry, 1923) sailed on April 9th on the "Empress of Japan" for China. Mr. and Mrs. Batstone had a sixteen months' furlough owing to unsettled conditions in Shanghai. They hope to resume their work in and around that city. Mrs. Batstone's address is c/o China Inland Mission, Shanghai, China.

Miss Emma Graham (1924) has been appointed Public Health Nurse for Richmond Hill, Ont. Miss Jean L. Cormack (1926) has accepted a position as Supervisor of the Medical and Surgical Floor of the Lutheran Hospital at Fort Dodge, Ia. Miss Helen Sims and Miss Jean Connell (1928) are doing private duty in Bermuda. Miss Hilda MacLennan (1928) has just returned from a trip to Jamaica. Miss Edna Moore has

been appointed Chief Public Health Nurse of the Division of Child Hygiene and Public Health Nursing for Ontario. Miss Moore's headquarters are at the Parliament Buildings, Toronto. Miss Viola Cardwell (1921), Miss Mae Cardwell (1927), and Miss Aubra Cleaner (1924), are enrolled in the Teaching and Administration Course for Nurses, and Miss Bessie Skinner (1929), Miss Helen Russell (1930), and Miss Dorothy Pinchin (1930), are taking the Course in Public Health Nursing at the University of Toronto. Miss Marjorie Shields (1930) has recently opened the Marjorie Jane Hosier Shop at 207 Elizabeth St., Toronto, Ont. Miss Dorothy Riddell (1931) is teaching school on St. Joseph's Island. Miss Katherine Elliott (1924) left recently on a Mediterranean Cruise. Miss Esther Strachan, Miss Anetta Landon and Miss Eugenie Stewart, all of the staff of the Toronto General Hospital, attended the provincial annual meeting held at Ottawa recently.

Staff Meetings: In October, 1931, the Staff Nurses of the School for Nurses, Toronto General Hospital, organised a Study Group for the year. The excellent attendance and enthusiasm of the nurses indicate that this enterprise has been greatly appreciated. Mrs. Ann Anderson Perry, a lecturer on Current Events, was engaged and consented to give her talks at the Residence, which was a great convenience to the nurses. Mrs. Perry's information on events of both world and local interest in a remarkably comprehensive way, was tinged very often with a subtle and delightful humor. Miss Isabel Lawrence, of "The Saturday Night," for one evening fascinated the nurses by her talk on "Books of the Year". Needless to say, this profitable and delightful programme was made possible by the personal interest of Miss Gunn. In addition to the Study Group, Staff Meetings from November until April took a most interesting and refreshing form. Under the convenership of Miss Gunn the following programme was presented:

"The Financial Administration of the Hospital"—Mr. R. W. Longmore, Chief Accountant.

"Rudimentary Business Law and Its Application"—Miss Edith MacP. Dickson, Chairman, Council of Nursing Education, Department of Health, Ontario.

"Recent Developments in Communicable Diseases"—N. E. McKinnon, M.B., Associate Professor of Physiology, University of Toronto.

"The Relation between Curative and Preventive Medicine"—J. G. Fitzgerald, M.D., Director, School of Hygiene and Connaught Laboratories, University of Toronto.

"Recent Developments in Medicine"—Duncan Graham, M.B., Professor of Medicine, University of Toronto.

"The Toronto General Hospital Recent Developments in Special Departments."

On three evenings the Report of the Survey of Nursing Education in Canada was studied.

QUEBEC

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The monthly meeting of the Alumnae Association was held on Monday, March 14th. Miss Frances Eaton, Registrar, Montreal Graduate Nurses Association, gave an interesting and instructive talk on "The Significance of Registration". Refreshments were served.

WESTERN HOSPITAL, MONTREAL: At the February meeting of the Alumnae, Dr. A. D. Campbell gave a most interesting and instructive lecture to the nurses, which was illustrated with lantern slides. Miss Violet Cross delighted all with her vocal selections, and a social half-hour was spent afterwards. Much sympathy is extended to Mrs. Howard Clouston, of Huntingdon, P.Q. (Margaret McRae, 1914), on account of the death of her father, which occurred recently at the Civic Hospital, Ottawa. Alumnae members are pleased to hear that Miss Alice Reinhardt has recovered from a serious operation performed at the Toronto General Hospital. Mr. and Mrs. P. G. Robertson (Christine Rowley, 1917), of Montreal West are leaving, shortly for Toronto, where they will reside. Mrs. Lewis Smith (Ruby Tessier, 1916), of Lower Coverdale, N.B., is visiting her sister, Mrs. C. T. Crowdy, Montreal West. Miss Ruth Leavitt (1918), who has been nursing in the State of New York for some time, is spending the spring months in California with her mother.

ROYAL VICTORIA HOSPITAL, MONTREAL: The annual dinner given by the Alumnae Association in honour of the graduating class was held on March 29th in the Ritz-Carlton Hotel. There were 200 guests present. The tables were decorated with daffodils and purple iris. There was much enthusiasm when the names of those who had led the Class of 1932 were announced. These were: Best practical work, 1st Division, Miss Grace Fowler, of Brown's Flat, N.B.; Best practical work, 2nd Division, Miss Marjorie Evans, of Saint John, N.B.; Highest standing in class work, 1st Division, Miss Constance Moule, Montreal, Que.; Highest standing in class work, 2nd Division, Miss Dorothy Riches, of Saskatoon, Sask. The toast to the King was proposed by Miss Gertrude Godwin, who presided. Miss Eileen Flanagan proposed the

toast to the Governors, and the toast to "Our Guests" was proposed by Mrs. M. A. Stanley. Miss Dorothy Riches proposed the toast to the Doctors, and Miss Sara Matheson "Our Absent Friends".

JEFFREY HALE'S HOSPITAL, QUEBEC: Miss E. A. Armour (1921), Lady Superintendent of Jeffrey Hale's Hospital, is enjoying a trip to Jamaica, British West Indies. Miss Marjory Semple and Miss Sarah McKeage left for South Africa, September, 1931, to do duty in a government hospital; later they will proceed to India to duty there in another government hospital. Miss S. Margaret Jamieson (1921) has resigned her position as Lady Superintendent of the Galt General Hospital, Galt, Ont., and has been appointed superintendent of the Brampton Hospital. Miss Muriel Fischer has been appointed corresponding secretary instead of Miss Douglas Jackson for the Jeffrey Hale's Hospital Alumnae Association.

VICTORIAN ORDER OF NURSES FOR CANADA

Districts 1 and 8, Registered Nurses Association of Ontario, have requested the National Office of the Victorian Order to conduct Maternal Care Institutes such as the three which have already been held in Toronto under the leadership of Miss Ethel Cryderman, Ontario Supervisor. New Brunswick and Nova Scotia are also asking for Institutes which will probably take place in the fall.

The Victorian Order of Nurses for Canada arranged a demonstration, given by Miss Muriel Winter, Toronto Branch, at the district meeting of the Ontario Medical Association held at Midland on April 13th.

TORONTO: Miss Marcele Smith, lately of Brampton and Burnaby (B.C.) branches, who has completed the four-months' course at the Canadian Mothercraft Centre, Toronto, has returned to the Order and is now attached to the Toronto Branch. Miss Elsie Keith, a graduate in Public Health Nursing, University of Toronto, 1931, has been taken on the local staff of the Order. Miss Thora Hawkes attended the annual meeting of the R.N.A.O. at Ottawa as delegate of the Women's College Hospital, Toronto.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

ARENS—In March, 1932, at Toronto, to Mr. and Mrs. Edward Arens (Frances Webster, Toronto General Hospital, 1925), a son.

BINET—On December 15, 1931, to Dr. and Mrs. Binet (Mae Silas, Jeffrey Hale's Hospital, Quebec, 1930), a daughter.

CARSON—Recently, at London, Ont., to Mr. and Mrs. Frank Carson (Doris Abbott, St. Luke's Hospital, Ottawa), a son.

CROSBY—In February, 1932, at Toronto, to Mr. and Mrs. Edward Crosby (Lorene Lowrie, Toronto General Hospital, 1922), a daughter.

DUNNETT—On December 18, 1931, to Dr. and Mrs. Dunnett (Edith Maybee, Wellesley Hospital, Toronto, 1925), of Brighton, Ont., a son.

GLEDHILL—On January 30, 1932, at Toronto, to Mr. and Mrs. T. L. Gledhill (Helen Blair, Toronto General Hospital, 1921), twin daughters; 207 Glencairn Ave., Toronto, Ont.

GRAHAM—On March 26, at Ottawa, Ont., to Mr. and Mrs. C. C. P. Graham (Amy Chase, Ottawa Civic Hospital, 1927) a son.
IBBOTT—On February 13, 1932, at St. Stephen, N.B., to Rev. J. T. and Mrs. Ibbott (Lillian Shand, Saint John General Hospital, 1920), a son—James Donald Shand.

KINSMAN—On February 6, 1932, to Dr. and Mrs. Kinsman (K. MacNeil, Wellesley Hospital, Toronto, 1926), of South Porcupine, Ont., a daughter.

MITCHELL—On December 10, 1931, to Mr. and Mrs. J. Mitchell (F. Saddington, Wellesley Hospital, Toronto, 1929), a son—James David.

McGOWAN—In January, 1932, to Mr. and Mrs. McGowan (Lorna Weatherlie, Jeffrey Hale's Hospital, Quebec, 1929), a daughter.

POOLE—Recently, at Fredericton, N.B., to Mr. and Mrs. W. J. Poole (Mary Robinson, Children's Memorial Hospital, 1930), a son.

STOCKLEY—In December, 1931, at Seaford, China, to Mr. and Mrs. Hanley Stockley (Jean Menzies, Toronto General Hospital, 1922), a son.

TANTON—In February, 1932, at Sundridge, Ont., to Mr. and Mrs. Charles Tanton (Myrtle Scott, Women's College Hospital, Toronto, 1924), a son.

WEBBER—On January 20, 1932, at Toronto, to Mr. and Mrs. P. Webber (Edith Ross, Toronto General Hospital, 1923), a daughter, Frances Anne.

MARRIAGES

BISSETT—WILSON—In January, 1932, Frances Wilson (Jeffrey Hale's Hospital, Quebec, 1929), to Mr. Bissett, of Montreal, Que.

HIPPISLEY — DUFFIELD — Recently, Helen Duffield (Vancouver General Hospital, 1931), to Mr. Wilfred Hippisley. They left for Ireland and England via the Panama and will return to Canada in July to reside in Ladner, B.C.

McKAY—ESSELMONT — On March 5, 1932, at Toronto, Ont., Annie Mary Esselmont, of Holly Lodge, Vancouver, to Donald Elliott McKay, of Fort William, Ont.

RAMSBOTTOM — WATSON — On March 20, 1932, at Windsor, Ont., Buelah Watson (Hotel Dieu Hospital, Windsor, 1927) to Harry Ramsbottom, of Windsor, Ont.

SHARP—GRANGER—On March 5, 1932, at Grimsby, Ont., Velma Granger (Hamilton General Hospital, 1930), to Dr. John Sharp, Toronto, Ont.

TAYLOR—WILKINS — On March 24, 1932, in Toronto, Mary Wilkins (Wellesley Hospital, Toronto, 1921), to C. Taylor, of Toronto, Ont.

WALLIS—PATERSON — On January 20, 1932, at Vancouver, B.C., Jean Paterson (Royal Jubilee Hospital, Victoria, 1927), to Major P. R. M. Wallis. At home, Shanghai, China.

DEATHS

DENNY—On March 27, 1932, at Kingston, Ont., Mrs. D'Esterre (Lois Denny, Toronto General Hospital, 1924).

DUNNETT—On January 4, 1932, infant son of Dr. and Mrs. Dunnett (Edith Maybee, Wellesley Hospital, Toronto, 1925), Brighton, Ont.

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Application forms, information regarding subjects of examination, and general information relating thereto may be had upon written application to—

**Miss A. M. MUNN, Reg.N.,
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Regular meeting first Tuesday in month.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

A.A., WINNIPEG GENERAL HOSPITAL

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Meetings held first Thursday every month.

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

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Regular Meeting—First Thursday of each month.

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The Third Biennial Canadian Conference on Social Work will be held in Winnipeg, June 7, 8, 9, 1932. On June 6th will be held the annual meeting of the Canadian Council on Child and Family Welfare, the Canadian Association of Child Protection Officers and the Social Service Council of Canada. Preceding these meetings a Public Worship Service is arranged for Sunday evening in Grace United Church, at which the speaker will be Rev. Canon Shatford, M.A., D.C.L., O.B.E., of Montreal.

Among Conference speakers are: Professor R. C. Davison from London School of Economics, an authority in industrial problems in Great Britain, and who has been associated with Sir William Beveridge in his studies on unemployment; Mr. H. H. Wolfenden, of New York, Consulting Actuary, Fellow of the Institute of Actuaries (Great Britain) who has made extensive studies into various contributory forms of social insurance in Great Britain and other European countries for insurance companies; Professor Frank J. Bruno, Professor of Applied Sociology and Director of Training for Social Work, Washington University; Dr. C. M. Hincks, General Director, National Committee for Mental Hygiene (U.S.A.) and Director of the Canadian National Committee for Mental Hygiene. A number of well known Canadian social workers will also participate.

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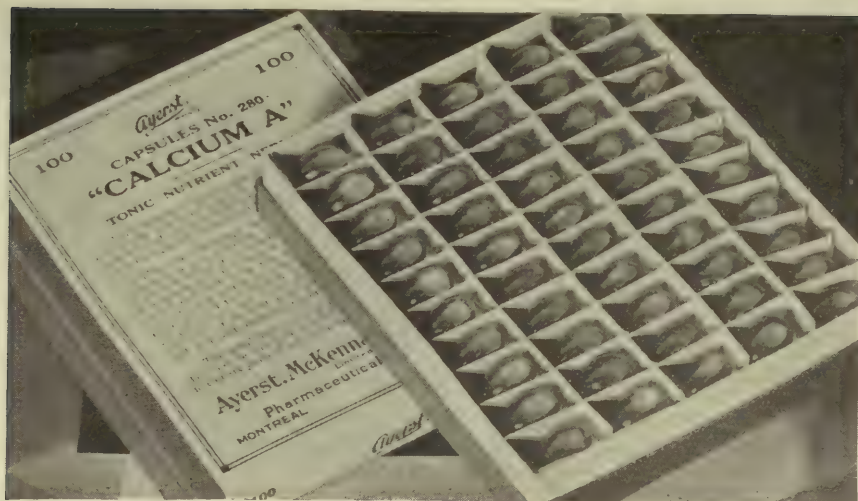


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Recent Advances in Obstetrics

By WILLIAM J. STEVENS, M.D., C.M., F.R.C.S., Attending Obstetrician,
Ottawa Civic Hospital.

The mother is the life of the family, the loss of whom in childbirth is a disaster. We realise that the wastage of maternal lives due to controllable causes is unnecessarily high. Maternal care should be the same the world over, whether the mother lives in the city or the country, in a palace or in a hut, she needs maternal care and nursing supervision, care and instruction during pregnancy, an aseptic delivery under the direction of a skilled obstetrician, and the same care until after she is able to resume her regular responsibilities and care for her baby. What part the nurse takes in this care differs in different communities, depending upon the available medical and nursing facilities and on the division of labour between the doctor and the nurse. The means of prevention and control of maternal, foetal and early infant mortality and morbidity are, largely, the education of the public to expect and demand good and consecutive pre-conceptional, pre-natal, intra-natal and post-natal care for mothers and infants.

It is really only during the last fifteen years that any concerted effort has been made to develop, by women, a demand for antepartum care and better obstetrical service. Widespread propaganda for pre-natal instruction is doing much to better the condition of the prospective mother and give the unborn child a better chance. However, pre-natal care, no matter how thorough, is but a link in the obstetrical chain, which is broken by faulty or careless methods of delivery. Furthermore, it must be remembered that for every woman who actually loses her life in labour there are four

or five whose health is permanently impaired by the effects of a difficult labour, as the method of delivery has an important bearing on maternal rates. Only consecutive and intelligent, rational obstetrics at the time of delivery, followed by post-natal observation for a period of two months after childbirth, will ever raise obstetrics to proper standards. One statistician demonstrated in a group of 5,000 mothers cared for by the Maternity Centre Association of New York during an eight-year period that the mortality was about one-third of that in the same area among other women, with a reduction in maternal rate of over 40% and of infant deaths of over 30% as compared with the control groups; in other words, that one out of every three women who die every year as the result of childbearing could be saved if they received satisfactory medical and nursing care, which means that two-thirds of these deaths are preventable. Pre-natal care, which is one of the best examples of preventative medicine that the medical profession has developed, is scarcely thirty years old. It has its greatest value in preparing the patient better to face the risk of labour and the puerperium, in reducing deaths in cases of disproportion and malposition, and in limiting the number of eclamptics. The patient should be assured of a safe delivery and should be free from anxiety and fear throughout the whole time: she knows the physician has a thorough knowledge of her physical condition and that she will not be taken by surprise at some abnormality that may occur as a result of no previous care.

Standards of Pre-natal Care

As soon as a woman suspects she is pregnant she should go to the physician for diagnosis, so that she may be under immediate supervision during the entire pregnancy. The physician at the time of the first visit should obtain a very careful history, make a complete physical examination and record all facts in a permanent history.

History: Family history of tuberculosis, insanity, hemophilia, cardio-nephritis or tumors.

Type of family labours and complications.

Past history: Previous diseases, especially scarlet fever, diphtheria, tonsillitis, rheumatism, cardio-nephritis, venereal and operations.

Previous pregnancies, miscarriages and puerperium. Weight and age of babies.

Present pregnancy: Ascertain date of last period, estimate expected confinement.

Note: Morning sickness, the menstrual molemina, vaginal discharge, bowels.

Physical Condition: Appearance.

Examination of mouth, teeth, tonsils, nose, thyroid, ears, heart, lungs, breasts, abdomen, legs for varicosities, spine, glands.

Abdomen: Presentation, position and fetal heart.

Pelvic measurements: Type of pelvis.

Vaginal examination: Pregnancy, cervix, position of uterus, adnexa, venereal, promontary of sacrum, width of pubic arch.

Urinalysis, blood pressure, complete blood count, Wasserman, weight.

Minute instruction is given in the following points in the hygiene of pregnancy:

Diet: Should be sensible and varied.

Diet control lessens the hazard of birth injuries both to mother and child.

Salt should be entirely omitted as seasoning.

Meat is best cut down as pregnancy advances. Carbohydrates and milk, etc., are best reduced in the last two months, to restrict baby's weight.

Over-eating, especially rich foods and fats, should be avoided.

Fruits, as oranges, grapefruit, apples, prunes, aid elimination, together with eight to ten glasses of water daily.

Proteins: Lean meat, eggs, fish, milk, etc.; vegetables as peas and beans.

Carbohydrates: Milk, cereals, bread, potatoes, rice, honey, sugar.

Fats: Cream, butter, oils, fat meats, cream cheese, etc.

Minerals: For bones and teeth, calcium in milk, beans, peas, cauliflower, spinach, dandelion greens, oranges, figs.

Iron: Obtainable from beef, liver, oysters, spinach, eggs, potatoes, codfish, tomatoes, prunes, strawberries.

Vitamines: Milk and its products, cod liver oil, meat, eggs, whole wheat, cereals, vegetables, fruit.

Weight: A regular gain of two to three pounds monthly is normal.

Exercise, Rest, Bathing: Moderate accustomed exercises without causing fatigue, such as a daily walk in the sunshine or easy gardening, is best. Avoid motoring over rough roads, long railroad journeys, lifting children, elevating hands over head, scrubbing floors.

A daily afternoon nap with clothes loosened and window open is advisable.

Baths: Tepid, avoid extremes of hot or cold; showers or sponges are best in the last month of pregnancy.

Light massage is helpful.

Vaginal douche only if ordered by physician.

Bowels: Develop regularity; may take daily liquid petrolatum and bran, prunes, figs, dates, oranges if necessary but avoid strong cathartics and enemata.

Kidneys: Are one of the most vulnerable tissues in the body during pregnancy. The urine should be examined at least every two weeks or oftener, if indicated, for albumen and sugar. A twenty-four hour amount may be saved if necessary.

Teeth: The child's withdrawing of calcium from the mother's bony tissues, together with the acid mouth secretion, causes teeth decay. The dentist should be consulted early, the teeth should be brushed morning and evening and after each meal, and the mouth rinsed with milk of magnesia. Also, give cod liver oil plus calcium.

Breasts: Should be left alone unless some emergency arises. Massage may help to develop small breasts. A breast pump or finger traction may elongate undeveloped nipples, which may be softened with olive oil or cocoa butter six weeks before delivery.

Preservation of Figure: Uplift brassieres tend to keep the breasts from sagging. Corsets, maternity or otherwise, or abdominal supports lend support and prevent undue extension. Massage with olive oil or cold cream softens the abdominal skin. Elastic stockings, worn throughout the day, support varicose veins. Proper exercise, chiefly walking, prevents stiffness.

Clothing should be sensible and hang from the shoulders. Avoid tight corsets, tight garters, which favour varicosities. High heels are bad, flat heels are proper.

Haemorrhage: In the event of a vaginal haemorrhage, the patient is advised to go immediately to bed, elevate the foot of the bed and notify the doctor. Every patient is advised to remain quiet at the time corresponding to her menstrual periods.

Maternal Impressions: The laity believe that the child may be marked because of some terrifying sight seen by the expectant mother. The fact that there is no nervous or circulatory connection between mother and child acts as a barrier for the prevention of any communication. However, pro-

found mental emotion occasionally causes abortion or premature labour. Early attempts at interference sometimes interrupt proper blood supply to the baby's head, leading to a monstrosity or an idiot.

Routine calls to doctor's office or clinic are made regularly every two weeks, or oftener, if indicated, at which call the patient makes a verbal report covering such conditions as ptyalism, nausea, vomiting, heartburn, fainting, cramps, varicose veins, hemorrhoids, leucorrhoea, bleeding, headache, epigastric pain, edema, shortness of breath. The urine is examined, the blood pressure taken, patient is weighed, hemaglobin tested, if anemic, and abdominal palpation examination if indicated, and routinely two weeks prior to delivery when the lack of engagement or disproportion may be evident.

The Toxemias of Pregnancy

Pernicious Vomiting: Morning sickness or nausea and vomiting is sometimes treated with a great deal of levity, being unfortunately regarded as a more or less normal sign of pregnancy. Often little sympathy or comfort is obtained until this condition becomes very serious. Neglect in this regard for a week sometimes means death to the prospective mother. Proper ante-natal instruction should prevent death here in the first three months of pregnancy.

The toxemias of pregnancy have a common factor underlying the etiological relationship between them, namely, the deficiency in the mother's carbohydrate reserve or storage of glycogen, due to extra foetal requirements. On account of the pregnancy, the extra burden to be maintained, the body requires a well-balanced diet. However, the patient often cuts down on her carbohydrate intake and takes little fluid, sometimes with a view to reducing her weight, causing nausea and vomiting, and this may result in inanition, starvation and dehydration, which may be aggravated by an indifference due to inexperience. Per-

nicious vomiting is best treated in hospital, with isolation, rest and nursing encouragement. Often no food by mouth is given for forty-eight hours; the pure carbohydrate, glycogen, is fed in the form of glucose, intravenously, 500 to 700 c.c. of a 10% solution once or twice daily, together with nutrient sedative enemata, sedatives and daily S.S. enema. Response is generally favourable if the patient's internal organs have not been damaged too extensively. Gradually, nasal or duodenal feeding or a dry carbohydrate diet, served appealingly by the nurse, with glucose by mouth, is taken, and in a few days time, the glucose works a wonderful change, and when instituted reasonably early, saves life in this very serious complication. The husband's blood is sometimes given intramuscularly, gastric lavage may be done, gland extract given or small blood transfusions. When all measures fail, evacuation of the uterus must be resorted to.

Eclampsia

Eclampsia, mostly regarded as a preventable disease, occurs 1-500 cases and causes 26% of maternal deaths in obstetrics. Proper ante-natal care with diet and regular observation should prevent this. The fits occur when the sugar in the blood is, at the time very low, showing the great glycogen or carbohydrate depletion of the mother's liver, which acts as a store house. Here also intravenous injections of glucose have a liver sparing effect, restoring glycogen to the liver and tissues, controlling the convulsions, lowering the blood pressure and stimulating diuresis.

Treatment: Prophylactic treatment in the form of pre-natal care stands out as one of the greatest contributions in the advancement of the therapy of the toxemias. It is well to assume that every pre-existing nephritic, every albuminuric or high tension case is a potential eclamptic, who should have ceaseless watching in her pre-natal period and pre-conclusive

interference to prevent the convulsive toxemia.

Nursing Care: The eclamptic must be treated very gently, hardly touched at all, tongue protected, and the utmost quiet observed. The patient may be blindfolded, her ears plugged with cotton, the room kept dark and warm, and her position should be changed four to six times daily. The eclamptic is best treated by ultra conservatism, the fits must be first controlled, before any attempts at delivery are made. The convulsions may be controlled by magnesium sulphate solution, 20 c.c. of a 10% solution intravenously, immediately after the first convulsion, and repeated every hour until the fits are controlled, or by morphia gr. $\frac{1}{4}$ or $\frac{1}{2}$ (hypo) and repeated after each convulsion. Other sedatives are used. When the convulsions are controlled, glucose is given intravenously, 1,000 c.c. of a 20% solution 2-4 times daily, accordingly, or by venoclysis.

Venesection may be done for blood pressure over 170, with 700 c.c. taken off.

Oxygen by inhalation is given after each convulsion.

Anaesthesia: Gas is best.

Consideration is given colonic irrigations of five gallons of 5% soda bicarbonate, hot packs and gastric lavage, leaving in 2 oz. of magnesium sulphate.

Interference: Labour should be hastened in the most conservative way possible by emptying the uterus in the safest manner, usually from below, sometimes by Cesarean section under local anaesthesia, just as soon as the convulsions are controlled.

Post-partum care is of vital importance. Once a patient has had toxemia with cardio-vascular-renal disease she should be studied most carefully between pregnancies, and in future gestations receive exceptional pre-natal care.

Other Complications

Anemia of Pregnancy: Fifty per cent. of all pregnant women have

anemia, making it imperative that obstetricians include blood counts in their routine pre-natal care. The treatment should be intensive by means of diet, iron, arsenic, together with blood transfusions, and liver in doses of $\frac{1}{2}$ lb. by mouth per day or the broth extract from $1\frac{1}{2}$ to 2 lbs. of liver, especially in cases of pernicious anemia during gestation.

Heart Disease: A bad heart contraindicates marriage; if married, the woman should not become pregnant, if pregnant, interruption can be considered. In severe heart cases, rapid delivery by Cesarean Section is of less strain than delivery by forceps even under a powerful narcotic. The patient should be warned pre-natally against exertion, advised absolute rest in bed with cardiac tonic if necessary, and delivered according to the decompensation.

Syphilis. Good pre-natal anti-syphilitic treatment will save upwards of 93% of babies, whereas pregnancy ends disastrously in 80% of untreated. Where the mother is treated early in pregnancy the baby is born healthy and free from the disease, otherwise a premature macerated foetus is likely.

Goitre: If goitre is present, pregnancy should be avoided if possible, but 90% can be carried to normal delivery if properly managed. Thyroidectomy may be successfully undertaken.

Diabetes: Insulin has helped the pregnant diabetic mother greatly.

Tuberculosis: Unless the disease is quiescent for two years, tuberculous women should be advised against marriage and they should have no children. Pregnancy should be avoided in active tuberculosis, especially

with any laryngeal involvement and interference if any, done in the first three months. At term the birth should be terminated as soon and as easily as possible. The mother should not nurse her baby.

Placenta Previa, of central or partial type, Cesarean Section is indicated together with blood transfusion before operation, accordingly.

Cesarean Section: The mortality in the best centres is 2.8% for clean cases, 6.2% for suspicious cases and 9% for unclean cases.

The use of high forceps is bad obstetrical technique, which has been abandoned in favour of version, Cesarean Section or craniotomy.

Abnormal Presentation: Breech or transverse presentations should be turned whenever possible. X-rays may diagnose multiple pregnancy, abnormal presentations and monstrosities.

Trichomonas Vaginalis, due to a motile parasite with flagellæ is the cause of an obstinate, foamy, purulent leucorrhoea simulating gonorrhoea. It may be treated with 1-4000 bichloride vaginal douches or vari-ously.

Elderly Primipara: Towards forty years of age or more the necessity for Cesarean Section is increased, the woman is more likely to have fibromyomas or a fibrous uterus. Breech presentation often necessitates Cesarean Section but a test of labour may be warranted.

Sex Determination is impossible to modify. Some advocate bicarbonate of soda douches to produce males and lactic acid douches to produce females.

(Concluded in next issue)

*Lead Poisoning in Children**

By Dr. H. S. MITCHELL, Montreal, Quebec.

Lead poisoning is a subject which has received considerable attention from time to time, and one which is of medical interest not only from the standpoint of diagnosis, but also from that of etiology. As the cases which are apt to receive more prominence are those in adults, and as lead poisoning is said to be an intoxication second in frequency only to alcoholism, it was thought that a brief presentation of two cases in young children would be of interest.

Plumbism in adults is nearly always due to occupational hazards. In children this is not so. The exposure is more subtle, the juvenile system reacts more severely to a much smaller exposure, and the manifestations of intoxication are different.

Except in rare food poisoning instances, lead is usually acquired as a manifestation of pica, that perverted appetite which leads children to indulge in ordinary repulsive objects. Occasionally the habit becomes almost a mania, and the child will go to unthought-of lengths to satisfy its perversion. Usually lead-painted chairs, toys and cribs are attacked and the amount of paint which these children can remove from a crib in the space of half an hour of diligent concentration is remarkable.

The amount of lead required to produce clinical symptoms is apparently variable and difficult to determine, but in one of our cases, viz, a two-year-old child, relapse followed a three weeks' resumption of paint eating; and in the younger case presented the total duration of lead eating was probably six to eight weeks before the cerebral symptoms developed.

The children are usually more or less irritable, but it is seldom that

they complain of the colic that plays such a prominent part in the adult form. Constipation is almost invariably present but seldom noticed or remarked upon by the parents, unless they are cross-questioned. There is usually some pallor; the lead line is frequently present, but less constantly than in adults. Peripheral neuritis develops in children but there is less tendency to involve the shoulder muscles. The legs are more frequently attacked in children; most important, the cerebral manifestations are more frequent, and often abrupt in onset.

The first case is that of a girl of nine years who was referred as a case of poliomyelitis on account of wrist and foot-drop. There was a history of colicky abdominal pains for several weeks, obstinate constipation, and during the two weeks previous to admission, tenderness in the muscles, with increasing muscular weakness. There had been no muscular cramps in the extremities. She stumbled when she walked, and could not use her hands properly to feed herself. On admission the striking thing was bilateral foot-drop and wrist-drop. The peronei, extensors of toes, and tibialis anticus were paralysed. The extensors of the hands on both sides were paralysed but the supinator longus was active. It is uncommon except in children, to see paralysis of the tibialis anticus. The mucous membranes were pale, the skin was pallid, and there was a very definite lead line on the gums. There were no cerebral symptoms, no optic neuritis and no neck stiffness nor head retraction.

Blood Examination: Red blood cells, 3.7 millions; white blood cells, 7,200; hæmoglobin, 73 per cent.

Bloodsmears showed 3-4 stippled red cells in every field.

It was noted at the time that the hæmoglobin was actually much high-

(*From the Medical Department, Children's Memorial Hospital, Montreal. Read before the Montreal Medico-Chirurgical Society, January 22, 1932.)

er than it might have been estimated. The pallor of lead poisoning is a striking feature and said to be due to vaso-constriction of the skin vessels. Spinal puncture showed clear fluid under pressure of 150 mm. water, and seven cells per mm. (lymphocytes).

She was given calcium lactate by mouth, high calcium diet, and the feet and hands were put in cock-up splints. Later massage was instituted. In six weeks definite recovery was in evidence and now (three months) she has almost complete return of function in the hands. The feet, as is usual, are slower in recovering.

Urine: Chemical analysis revealed the presence of lead in small quantities.

The second case is a female child of three years. She was referred to the hospital in generalised convulsions of sudden onset, following a short period of a couple of weeks of general ill health, marked constipation, irritability and projectile vomiting. During the last 36-48 hours she had developed a squint. This led the family physician to strongly suspect tuberculous meningitis; also she was quite pale and the question of a co-existing blood dyscrasia was raised.

On admission the child was semi-conscious, and when undisturbed lay on her side, head retracted, in a stuporous condition. Although there had been several convulsions during the day, none followed admission to hospital, in spite of the absence of immediate institution of specific treatment. There was marked pallor of the mucous membranes. There was a strabismus, definite neck stiffness and questionable bilateral Kernig's sign. Bilateral papilloedema was present. The knee jerks, ankle jerks and biceps tendon reflex were all present and slightly exaggerated. The abdominal reflexes were present. There was no Babinski. There was no paralysis of any muscles of the extremities. The only muscle paralysed was the lateral rectus of the

left eye. Examination of the heart and lungs was negative. The lymph glands were not palpable. The bowel contained large palpable fecal masses. The liver and spleen were not palpable.

Blood Examination: Red blood cells, 3.4 million; white blood cells, 22,100; hæmoglobin, 50 per cent.

A stained film showed anisocytosis, large numbers of stippled red cells, occasional normoblasts, and occasional myelocytes.

Lumbar Puncture: Clear fluid, pressure 170 mm. water, cells 200 per c.mm., all lymphocytes. Pandy's test for globulin was strongly positive. No organisms were found on smear or culture (including search for acid fast organisms). The spinal fluid contained 154 mgms total protein per 100 c.c. but did not give a positive test for lead.

An intradermal injection of O.T. 1 in 1000, 1/10 c.c. was negative. In the meantime a faint but definite lead line was discovered on the gums. An x-ray taken, looking for possible calcified abdominal lymph glands showed none, but characteristic findings of plumbism at the ends of the ribs. X-rays of the epiphyses at the wrist revealed the same thing.

On questioning the parents, the source of the lead was found to be in eating furniture paint.

Improvement was continuous and rapid following interruption of the paint-eating, the administration of a high-calcium diet, calcium lactate by mouth and calcium gluconate intramuscularly. De-leading was later carried out by administration of ammonium chloride and a low calcium diet.

This case demonstrates that lead poisoning should always be borne in mind as a possible cause of convulsions of obscure origin.

The question of renal impairment is frequently raised in connection with lead poisoning. The younger child has not been investigated along this line, but the older child shows

no evidence of disturbance by the Mosenthal test, although her urea concentration factor is lower than normal. She has no albuminuria.

In the last few years a further impetus to the study of plumbism was given by Vogt, Park, and others who described special changes in the ends of growing bones in cases of lead poisoning. In several proven cases of lead poisoning it was found that there was a broad dense area in the x-ray picture at the ends of the long bones.

Specimens from autopsy material which have been studied showed that there was four times as much lead in the dense areas as farther back in the shaft of the bone. It was also demonstrated by Park that, in microscopical sections of the specimens in plumbism, the trabeculae are much more compact in these radiologically dense areas. Therefore, whether the radiological appearance is due to one or both causes is not yet definitely proven.

Dense lines are found at the ends of growing bones in several conditions, notably healing rickets, scurvy and congenital syphilis. But as this is associated with other characteristic signs, there should be no confusion. The rare condition of marblebone should be borne in mind.

It is not claimed that these x-ray findings are characteristic of plumbism alone, as there is good reason to believe that other heavy metals such as bismuth or arsenic may produce similar effects. And it has been known for many years that phosphorus produces a somewhat similar picture. Nevertheless, the discovery of such an x-ray appearance should raise the question of lead poisoning, especially in an otherwise normal bone; and its demonstration in a suspicious case may be regarded as confirmatory evidence.

Treatment: For many years in addition to magnesium sulphate by mouth, and general dietetic and hygienic supervision, the most used drug was potassium iodide. Later sodium thiosulphate was introduced. Both these preparations very definitely increase the elimination of lead. But in the neurological crises, where there is already too much lead in the circulation it is obviously desirable to remove it rapidly. As shown by Aub, Minot, Fairhall and Petznikoff, the administration of a high calcium diet, augmented by calcium lactate by mouth, or calcium chloride intravenously, rapidly removes the lead from the circulation and concentrates it in the bones. By this means the acute phase of the intoxication is easily controlled. Later on, when the acute symptoms have subsided, elimination may be proceeded with. This is accomplished by altering the hydrogen-ion concentration of the blood, either by administration of acid or alkali; the same workers have shown that the combination of an acid salt (ammonium chloride) with a low calcium diet gives the best results.

It is sometimes argued that if the lead can be satisfactorily stored in the bones, it should be left there, and the patient kept on a high-calcium diet or in a so-called positive calcium balance. But as it has been so clearly shown experimentally, in addition to the clinical knowledge, that an acidosis may suddenly release into the circulation large quantities of lead, this temporising may have serious results. In carefully controlled adults theoretically such a stand may be justifiable, but the frequency of acidosis in children, occurring either independently or in association with their many infections, leads one to feel that it is wiser to proceed with elimination of the lead in a quiescent interval, than to run repeated risks of acute saturnism.

A Case Study in Lead Poisoning in a Child

By SYLVIA FISK, Student Nurse, Children's Memorial Hospital, Montreal, Quebec.

Ameline, aged nine years, was admitted to the Children's Memorial Hospital on November 4th, 1931.

Complaints on Admission: (1) Weakness of arms and legs for one week; (2) Loss of appetite, one week; (3) Pain in abdomen, two weeks; (4) Pain in the limbs, three weeks.

Previous Medical History: Her mother stated that she had never been very healthy. She had "colic" many times as a baby, also measles, scarlet fever and pneumonia. Two years ago a tonsillectomy and adenoidectomy was done.

Family History: Her father and mother are thirty-one and thirty years old, respectively, and are living at home apparently healthy. There is one other child, a little boy, one and one-half years old, who is also well. There is no history of tuberculosis, syphilis, rheumatic fever or cardiovascular disease in the family.

History of Present Condition: About the middle of October Ameline complained of pains in the arms and legs. She had a peculiar manner of walking which her mother noticed. She complained of tiredness and showed a desire to stay in bed. Her appetite was poor. She was very constipated. The weakness in her arms and legs grew worse and her mother took her to the out-patient department where admission was advised.

Social History: Ameline was living at her home in a congested area of the city previous to her admission to this hospital. It is in a very poor district and the surroundings are most undesirable. Her father has been without work for some time and the family is in straitened circumstances. When at home Ameline says she sleeps in a small room by herself. They are French-Canadians and speak little English.

The parents seem very fond of their daughter and bring her such

playthings as they can afford when they visit her. Ameline says she has been attending school, and is bright and alert for her age.

Physical Examination: The child appeared well-developed and well-nourished. The mucous membranes were all rather pale and the skin was also rather pallid. The striking feature, however, was bilateral foot-drop and wrist-drop. Examination of the heart and lungs was negative. No abdominal organs could be palpated. The superficial lymph glands were not enlarged. Examination of the nose and throat was negative. There was, however, a very definite blue line at the margin of the gums, and she had several carious teeth. The neck was not rigid and there was no Kernig's sign. There were no pathological reflexes. Examination of the fundi showed no abnormalities, the reflexes were normal.

Laboratory Examinations:

1. Blood Count: Red blood cells, 3,700,000 per c. mm.; white blood cells, 7,200 per c. mm.; hæmoglobin, 73 per cent. Showing secondary anaemia.

2. Blood smear showed stippled red blood cells, which is an important diagnostic sign.

3. Urinalysis: This contained no sugar or albumen. A chemical examination revealed the presence of lead in small quantities.

4. Lumbar Puncture was done on admission. About five cc. of clear fluid were withdrawn under normal pressure. The cell count was five per c. mm. There was no increase in globulin.

5. X-ray revealed a dense white line at the epiphyses of the bones.

Diagnosis: The wrist and foot-drop pointed to a peripheral neuritis and the discovery of lead in the urine with the stippled cells in the blood, secondary anaemia and x-ray find-

ings seemed to indicate that the case was one of chronic lead poisoning.

Treatment: The patient was given a high calcium diet, and calcium lactate gr. x, t.i.d., p.c. Laxative in the form of magnesium sulphate dr. ii was given once a day.

Plaster of Paris splints were applied to the arms and legs. Massage was given. When the acute stage is passed this is to be followed by ammonium chloride in large doses and a low calcium diet.

Convalescence: Ameline is now convalescing. Her wrists are nearly normal. The feet are usually slower in recovering. She has almost complete use of her hands. There is no tenderness in the muscles now.

Since admission Ameline has gained six pounds in weight. She is now approximately the average weight for a child of her age and height. Her colour is much improved.

She is bright and talkative, easily amused and obedient. She understands English and can speak a few words.

Diet: Ameline was put on a high calcium diet. Milk is given freely as this is very high in calcium. Milk products, legumes, cauliflower, fruits, eggs, and some other vegetables are given her along with sufficient other food to make up a well-balanced diet. Her meals are served attractively and Ameline has a fairly good appetite.

At first she was unable to feed herself but since the improvement in the muscles of her arms the splints are removed at mealtimes and she is allowed to feed herself.

Nursing Care: Ameline has a bed-bath each day. Her heels and back are given special care as these are apt to become reddened and sore. They are well rubbed with alcohol and powder, applied at least twice during the day. The splints are padded with rolled wool. Her arms and legs were carefully handled because of the tenderness of the muscles. This has subsided now, and she is not complaining.

Ameline brushes her teeth each morning. In the afternoon she has her face and hands washed and her teeth cleaned again. Her bed linen is changed as often as necessary.

On admission Ameline had pediculi. Oil of sassafras was well rubbed into the scalp and her hair enclosed in a capeline. The next morning her hair was thoroughly washed. Tincture of quassia was applied to remove the nits. Each morning her hair is fine-combed, a solution of two per cent. Lysol being at hand, in which to place the comb.

The constipation and irregularity of bowel movements were corrected by the laxative.

If the weather is suitable Ameline is wrapped up warmly and is put out on the gallery each morning. This she enjoys very much.

New Points Learned:

1. The causes, symptoms and treatment of lead poisoning.
2. The difference between lead poisoning in adults and children.
3. The importance of x-rays in diagnosis.
4. Foodstuffs rich in calcium, and the part diet takes in treatment of disease.
5. The importance of caring for the skin beneath splints.

References Read:

1. Osler's Principles and Practice of Medicine: McCrae; Section iii; Lead Poisoning.
2. Cushny's Pharmacology and Therapeutics: Edmund and Gunn; Part iii; Heavy Metals and Metalloids; Lead.
3. Materia Medica: Blumgarten; Page 78.
4. Materia Medica: Dock; Pages 218-220.
5. Diseases of Children: McComb; Pages 248-253.
6. Practical Dietetics: Pattee; Page 793.
7. Elementary Household Chemistry: Snell; Pages 193, 211-217.

Discussion of Lead Poisoning:

The blue line on the gums is a valuable indication of lead poisoning, although it may not be present if the mouth is kept clean and in good condition. The lead is absorbed and con-

verted into a black sulphide by the action of sulphuretted hydrogen.

The wrist and foot-drop that is present in lead poisoning is really a form of paralysis. The cause of this paralysis is a peripheral neuritis and degeneration of the nerves. The fingers first become flexed, later, the wrist. This remains, so simulating wrist-drop. The muscles most used are first affected. The splints were applied for the purpose of immobilisation, to avoid any additional strain on the muscles and to correct the foot and wrist-drop.

Lead may gain entrance to the body through the lungs, digestive organs, or skin. It is carried in the body as a phosphate and is stored in the bones. An excess of calcium favours the harmless storage of lead in the body so during the acute stage calcium is given freely in the diet and in the form of medication to try and hold the lead in the bones. It is stored in the bones and shows up in x-ray by the dense white line appearing in the epiphyses. This phenomenon may occur in other diseases as scurvy and

rickets, but as it was accompanied by other symptoms no doubt was felt as to the diagnosis.

Although lead appears to be absorbed rapidly into the body it is excreted slowly. It is chiefly eliminated by the gastro-intestinal tract. For this reason the laxative was given.

Lead is found in most tissues in the body but it particularly affects the kidneys. For this reason urinalysis was made frequently and albuminuria fearfully watched for.

The purpose of the low calcium diet will be to remove the lead from the bones. The ammonium chloride hastens the elimination.

In adults, lead poisoning appears as an occupational disease usually being chronic in form, thus differing from children in whom the cause of the disease is accidental.

"Lead colic" is a more pronounced feature in adults than children.

Lead poisoning usually occurs without fever. Throughout the patient's course in the hospital her temperature did not vary very much.

On the Old Fort St. John Trail

By MARY ELLIS CONLIN, Nursing Branch, Department of Health, Alberta.

Old timers seeking their fortune in furs or gold have travelled this winding trail for many a year, but it is only within the last two or three years that some twenty-two hundred people have chosen this land to set up home making. Many of these people come from the dried-out areas of Saskatchewan and Southern Alberta, where the farmer had not seen a crop, nor the horse green pastures and running streams for several years. Imagine what an Eldorado even muskeg country would seem to them. Trees! Trees! Shelter for man and beast, to say nothing of firewood right at their front door. And water!

plenty of it. It does not matter if one must carry an axe to make a new trail where the old rut has worn too deep, or if one becomes bogged returning from town some 62 miles away. These are surmountable barriers compared to the hopelessness of tilling land which refuses to yield a harvest for their labour. "Open Air Camps" are visible all along the trail. At one of these spots we picnicked, the driver and her companion, brought along to help us out if we should get stuck. We did need him too. Trying to drive through several feet of freshly turned-up muskeg requires considerable "push and pull."

The Alberta Government has its big caterpillar road machine working, building a new highway through the country where these homesteaders are located. Not that old Peter Grenier wants it. When questioned by one of us as to whether he was content to see this new highway go in, he remarked: "Oh, we do not want a highway, just give us a trail good enough to get to town once a year, that is all we need." This is the sort of fellow who will go still farther north, when civilisation moves up to his door.

It is right here that the Honourable Mr. Hoadley, Minister of Health for Alberta, saw fit to place a district nurse. A meeting was called on three days' notice to organise a district and old and young attended. Such enthusiasm! A group of four husky young men volunteered to commence the cellar the very next day. Another group agreed to go into the heavy timber and haul logs, still another group promised their time to build the house, and lastly, two efficient carpenters, present at the meeting, agreed to finish it up so that a nurse could be sent in three weeks later. Tragedies in several families occurring during the last year, owing to the lack of medical help, the nearest doctor being 62 miles, and the nearest railway station and telegraph office some 50 miles, caused these new settlers to be so energetic in doing their share towards obtaining the services of a nurse.

Promptly at the end of three weeks, a letter was sent to the Department of Health announcing that there would be a dance given in the nurse's cabin on a certain date, and asking that the nurse be sent in in time to be present so that she might meet the people. What a scrutiny she will be subjected to, but she has nothing to fear for these people need her, and she is well equipped in training and experience to take care of them.

She will have some difficult traveling in all sorts of conveyances. In the springtime when the water comes down from Clear Hills, four miles distant, she is likely to be seen on horseback most of the time, but it is a new district, and that means the opportunity of putting her stamp on good work done, and a new field properly organised—there's always a thrill when you are the one that is doing it.

Most of the furniture will be built on the spot, as freighting over the trail is a wearisome and expensive job, but a comfortable chair, bed and blankets are being sent in to insure rest when weary days are done. A well filled medicine chest in a tidy dispensary will always be ready to serve the people's needs, and one more district will be grateful for insuring the care of mothers and babies and administering first aid to the male population by placing a well-trained and experienced nurse at their disposal.



The Benefit of Psychology to the Nurse and Doctor

By S. MARGARET JAMIESON, Superintendent, Brampton Hospital, Brampton, Ontario

Records of abnormal mental phenomena reach back to the dawn of history and can be found in the oldest books of both Eastern and Western worlds.

In the Old Testament, one reads of Saul's peculiar mental conditions at various times, and also of the behaviour of Nebuchadnezzar.

We find Ulysses simulating madness to justify his abstinence from the Trojan War, and David assuming madness to escape from Achish, King of Gath.

The general conception of this condition, at that time, was that the afflicted person was possessed by a demon. With the coming of Hippocrates, treating insanity as a disease of the brain made some headway in Greece, but the Dark Ages temporarily obscured the light and the old idea of demon-possession held sway. Witchcraft was but another phase, and history gives us many vivid pictures of the various means employed through the ages to stamp out this condition.

The phase of demon possession passed and one where the mentally ill were segregated in dungeons was ushered in. Terrible was the misery and suffering of these people. The first alleviation of their misery was started in England, and, shortly after, work along the same line was started in France.

What is vaguely called insanity is really a wide range of greatly differing conditions and diseases, all playing havoc with our organ of conduct and behaviour and its functions.

The imbecile, the hysterical, the epileptic, the insane and the criminal were formerly regarded, sometimes as saints or prophets, sometimes as wizards or witches, often as the victim of demoniac possession; on the one hand to be revered and worshipped,

or on the other to be burned or otherwise tortured.

Until very recent years, the mental aspect of nursing care has been almost entirely neglected, to the great detriment of nurse and patient in particular, and in general, to the world at large.

The nurse meets the mental and nervous element in every case of physical disease or injury with which she comes in contact, but never having been taught to recognise this element, its significance escapes her. Her failure to recognise this element should not be called carelessness, because the nurse has not been taught and trained to observe the symptoms. Due to the nurse's almost entire lack of knowledge of the primary obscure symptoms of insanity, many cases under her care have become permanently insane who might otherwise have been saved or helped. Again through her lack of understanding, the malady may be aggravated by the nurse's endeavour to argue about the delusion and convince her patient of the fallacy of his idea. Watching symptoms and finding causes for them is very important. The nurse has many opportunities for observation which the doctor has not. Some training in mental work gives a nurse an entirely different viewpoint.

Most people think that real mental patients are disturbed or distressed all the time, not realising that at times they are quite normal. They do not realise that often these patients are not so different from those of us who are well and that each patient must be treated as an individual and that groups can never be treated collectively.

It is only within the last fifty years, or perhaps sixty, that there has been any clear recognition of the vast importance of the mental factor in the

production and treatment of disease. Professor Thorndike has stated that any person with a temperature of 100° F. cannot be counted mentally normal. If this statement be true, and there seems to be no reason to doubt it, one at once sees the necessity and great importance of the nurse and doctor having, at least, a working knowledge of the truths and principles of psychology as applied to their particular work in preventing and curing or alleviating mental and physical illness.

The first psychological laboratory was created in Leipzig, Germany, in 1878. Since then, psychology has progressed slowly but surely until at the present day practically all worth while universities have laboratories in charge of men who are making a name for themselves and their university in the work they are doing in research and practical application of the truths they have discovered.

In the medical profession, especially among French-speaking people, there first came into existence a definite system of psycho-therapeutics, in which suggestion and other agencies were assigned their rôles, and principles were laid down to indicate the scope of these agencies and the means of turning them to best advantage. Three main agencies which are utilised by the practitioners of this branch of medicine, are those of self-knowledge, self-reliance and suggestion.

The graduate nurse from the general hospital is not well equipped to care for the functional nervous diseases. Therefore, special training for those who elect this work is sadly needed.

If the nurse is to be more than a glorified lady's maid, rendering her patient more and more dependent as a result of her ministrations, she must learn how to lift the patient out of the old involved life, into a new and more wholesome atmosphere. There is nothing in modern medicine which seems more promising for humanity

than a system which may so calm and steady the tortured mind that material opportunity may at least be successfully grasped and that spiritual truth may eventually be understood. There is no clearer sign of medical progress than the present rapid adoption of the principles of the work cure in the sanatoria and mental hospitals of the world.

In the general hospital wards associated with physical illness, we see delirium, depression, excitement, neurasthenia, psychasthenia, paranoia, deterioration and other psychoses; in fact, almost all conditions, more or less defined, which one finds in the special or mental hospital.

The general hospital physician or nurse seldom recognises these conditions and they are left uncared for. The patient is fed, bathed and given the treatment and medication prescribed, but no time is taken to inquire into the reason why he is cross or irritable, why he weeps or laughs, etc. He is frequently described as selfish, ungovernable, intolerable, impatient, and no effort is made to understand the why and wherefore.

Prevention is the watch-word in mental work and to the well-equipped nurse is given the opportunity. But one cannot do preventive work if one does not know what should be prevented, nor can one observe without a knowledge of what to observe, and the mental and physical life are so closely related that one cannot consider the one without the other.

It is important that the study of the phenomena of mental disease should be made obligatory on medical students and nurses. Such disorders are encountered daily in the routine of general medical practice or of nursing. How few there are who are able to discriminate between a toxic delirium due to an infection, a fever, a poisoning by iodoform or some apparently harmless remedy used in medicine or surgery, etc., and a well developed form of mental disease requiring close study and watchful care.

And yet the future of the patient may be permanently affected for weal or woe by the prompt recognition of the condition.

The nursing care of mental disease can never be adequately accomplished until it is placed in the hands of educated women who are trained for it and are familiar with general nursing, but who have secured an insight into the higher privileges of the nurse, which are acquired only by actual contact with mental cases.

The only real test of health is its serviceableness to the needs of life. We have an unhealthy state of the personality before us wherever the equilibrium of the human functions is disturbed in a way which diminishes the chances of existence, and the seriousness of the ailment depends upon the degree of this diminishing power. Seen from a strictly psychological viewpoint, we must expect a broad borderland region between the entirely normal, well-balanced life and that unbalanced disorder of functions which really interferes with the chance for self-protection and effectiveness.

The conduct of the insane is usually anti-social and it is this criterion which usually determines whether or not the patient is confined to a mental hospital or not. Also dissociation has been carried to a degree incompatible with normal thought and behaviour, and the mental processes are allowed to pursue their course quite undisturbed by the contradictions presented by the facts of experience.

In hereditary insanity, the probability of transmission depends, as well as the severity of the disease, upon the severity of the disease or degeneration in the parents.

Mental disease is described as a marked failure of adjustment to one's surroundings. Mental hygiene must deal, therefore, not only with intellect, but with conduct; and the child must be developed so as to think clearly and to live harmoniously with

others in his little world. Habits of mind must be formed with at least as great care as are table manners and social grace. Each of us is a compound of tendencies inherited from a variety of ancestors, and while a child of recognised neurotic inheritance requires more careful mental guidance, all should be prevented from developing unhealthy habits of thought and conduct. Lack of self-control is an outstanding feature of many mentally unbalanced people. Parents should teach and preach the doctrine of substitution for the unattainable, with consequent peace of mind.

By a campaign for mental hygiene is meant a continuous effort directed toward conserving and improving the minds of the people; in other words, a systematic attempt to secure human brains so naturally endowed and so nurtured that people will think better, feel better and act better than they do now. Such a campaign was not to be expected before the use of modern medicine. For, only with this have we come to look upon states of mind as directly related to states of brain, to view insanity as disordered brain-function and to recognise in imbecility and in crime the evidence of brain defect. Now such unfortunates are looked upon as patients with disordered or defective nervous systems, proper subjects of medical care; some of them are curable; some are incurable, but still capable of being educated to social usefulness; a part of them are socially so worthless, harmful or dangerous as to make their exclusion from general society necessary. It is but a short step from such a reformation of ideas to the realisation that less marked deviations from normal thought, feeling or behaviour are also evidences, either of brains defective from the start or made abnormal in function by bad surroundings or by bodily disease.

Modern medicine has taught us to recognise that the conditions necessary for a good mind include: first, the inheritance of such germ-plasm

from one's progenitors as will yield a brain capable of a high grade of development to individual and social usefulness; second, the protection of that brain from injury and the submission of it to influences favourable to the development of its powers. If these doctrines of modern medicine be true, the general problems of mental hygiene become obvious. Broadly conceived, they consist in providing for the birth of children endowed with good brains, denying as far as possible the privileges of parenthood to the manifestly unfit, who are almost certain to transmit bad nervous systems to their offspring, and also in supplying all individuals, whether ancestrally well begun or not, with the environment best suited for the welfare of their mentality.

Mental hygiene of a prophylactic nature falls into two classes: group preventive mental hygiene and individual preventive hygiene. The latter requires very special work. In looking at a child and frequently an adult, one is conscious that his only chance of having a useful and happy life is through teaching him to overcome and replace certain accustomed ways of thinking and feeling.

Thought and emotion are both instigators to action. Emotion both in the child and the adult is largely the motivation or driving force as regards action. Some emotions, for instance, fear and rage, appear in the earliest days of infancy. If these emotions are not properly trained and educated they may bring disastrous results on the individual and the community.

Training should be directed early to narrowing the expression of the unhealthy emotions and to broadening the capacity for happy and wholesome feelings. Jealousy must be rooted out, suspicion destroyed, the habit of depression and anxiety must be combatted by habitually smiling and taking a courageous attitude toward life.

Moods on which young people sometimes pride themselves should be discouraged, since they may be the starting points of nervous difficulties, not to say of insanity.

Among all the predisposing causes of nervousness, the first place must be assigned to drunkenness. No other source of mental and nervous disease can be pointed to with anything like the same certainty. Alcoholic poisoning is believed by many eminent physiologists to infect the reproductive germs, in opposition to Weisman's theory, which certainly finds no support in the history of nervous disease. It is certain that the posterity of drunkards suffers to an almost incredible extent from the milder and from the severer forms of mental and nervous disease. For this reason, the great neurologists, Foil, Mobeus and Weir Mitchell, have been great advocates of temperance. Nervousness is regarded peculiarly as a disease of girls and women, but a nervous system which requires frequent alcoholic stimulation in order to function is certainly diseased.

It would seem almost superfluous to emphasize the extreme injury that idleness produces. We know that an idle child usually becomes mischievous and incorrigible, and that adults without occupation of some kind will sooner or later develop habits and ways of thinking harmful to themselves and others. The same condition that is so pernicious, that a normal person cannot withstand its fatal blight, can hardly be other than deplorable for those already impaired. Idleness is a fictitious term in reference to mental activity, for if it cannot function normally, it will function abnormally.

Psychology has made possible the modern advance in the study and intelligent treatment of mental processes and actions, both in those called mentally ill or mentally normal. The causal view only is the view of psychology, the purposive view lying outside it.

Every psychical fact is to be thought of as an accompaniment of a physical process, and the necessary connections of these physical processes determine, then, the connections of the mental facts.

In psychomedical problems everything belongs which allows the application of causal psychology in the interests of health.

Physiotherapy attempts to cure the sick by influencing the body, perhaps with drugs, medicines, electricity, baths or diet. Lady Macbeth was treated thus, without success, as with her it was the mind which was diseased. In opposition to physiotherapy is that of psychotherapy, which is the practice of treating the sick by influencing the mental life. Psychiatry is the treatment of mental diseases only. In psychotherapy one must not be content with merely giving advice based on well-established psychological principles, but must give the patient something to do, something which will make him an active participant in bringing about his cure.

Re-education of thought and will, so that a better adjustment may be made, can often be brought about by the nurse, who, in homes, gains a better insight into many undesirable factors which the doctor never would in his few moments while visiting the patient. Through the training of thoughts and feelings, there is a continuous effort to lead the patient outside the narrow walls of self into the life of the community. Most of the "nervous" and insane patients are out of harmony with their environment. It is social maladjustment. To get them into a larger life—to make them feel themselves a part of the striving, courageous world—is to lead them away from dangerous introspection. Most of these "nervous" patients muddle along through painless days, their lives a patchwork of ill-matched activities, miscellaneous, heterogenous—leading nowhere, save to a nervous breakdown.

A few methods of applying therapy, most of which it is possible for

a nurse to use in greater or lesser degree, are enumerated:

Environment Therapy does not mean a change of scene only, or getting away from irritating surroundings, but the bringing in of new surroundings where imitation may have an opportunity to act in a health-restoring way.

Amusement Therapy is far more needed today than is realised. In the nursing field, and also among young working women and poor children, this opens up a very wide field for work of which the value has not yet been estimated.

Occupation and Work Therapy—The kind of work given is important as each kind of employment has an intellectual influence. But occupation therapy may not be satisfactory, as it may allow certain minds too much time to surrender themselves to unhealthy imaginings. In these cases, work therapy would be found useful. It may remove financial worries, but will, as well, take the attention and interest away from the field giving rise to the mental disturbance. Enforced work therapy may seem drastic in some cases, but the fact remains that it is often the only kind of psychotherapy available.

Isolation Therapy is too little used. By this is meant the keeping of a "quiet hour."

Electrotherapy is a newly developing field which gives a nurse large opportunities. Due to her knowledge of anatomy, physiology and chemistry, she has a good foundation to start on, and later can apply it intelligently and effectively, after being specially trained in the technique and theory of electrotherapy.

Music Therapy can be frequently used with good effect. This was used in Old Testament times, as we learn from the life of King Saul.

Physical exercises frequently possess valuable therapeutic powers, perhaps most useful with those not in the habit of developing the physical.

Many and varied must be the motives supplied in order to induce the majority of the mentally ill to do work of any kind. In furnishing motives, we must bear constantly in mind that our patients are deprived of the ordinary stimuli of life. The stimulus of necessity is taken away as well as that of ambition, competition, love of adventure and of expressing affection for dear ones by working for them.

The tangible results of occupation methods, while difficult to estimate in the laboratory sense of estimation, are sufficiently evident to be convincing. Large numbers of chronic patients can be re-educated to some degree of usefulness and to a greater degree of contentment; occasionally buried talents are discovered which are surprising.

In our public schools, a place for the application of psychological truths is slowly being made. Today, in many schools, mental tests of different types are being used to grade the ability and the progress of the pupils. Through these means systematic grading of pupils can be obtained, with better results both for the genius or those mentally deficient, as each will be, or can be, placed in his or her proper niche and taught and treated as they severally require. If it is impossible to have a psychologist do this work, it is quite possible for the teacher with some training in the method of using these tests, to grade her pupils by many of these tests, or

the school nurse may do so—if she has time.

In our colleges, the principles of psychology might well be more generally applied, for the benefit of the students. If this were done in our schools and colleges, those in need of special care or treatment might receive it, resulting in many averted tragedies and much good to all.

The law courts of today are finding that psychology explains many a puzzle and aids in giving judgment in many cases, for it is becoming more recognised every day, that a great part of the criminal world is composed of people who should be segregated, but who are capable of earning their living under proper supervision. If left at large they are a menace to humanity and breakers of law and order.

The hospital training school for nurses is an important field, much neglected, where mental tests could be used to great advantages. So many misfits from all other educational fields are deposited on the training school doorstep, that such a protection, especially to the sick, is a vital necessity. It would avert many a personal tragedy, many mistakes, misunderstandings, and provide a much higher type of woman for our future nurses. Incidentally, might such a sorting out process not have a salutary effects on the present situation of apparent unemployment among graduate nurses?

If radio's slim fingers can pluck a melody
From night—and toss it over a continent or sea;
If the petalled white notes of a violin
Are blown across the mountains or the city's din;
If songs, like crimson roses, are culled from the thin blue air
Why should mortals wonder if God hears prayer?

—ETHEL ROMIG FULLER.

History of the Saint John River

By FRED. H. PHILLIPS, Saint John, N.B.

The Rhine of America—perhaps this appellation is almost as old as the name given to the river by Samuel de Champlain on St. John the Baptiste's Day, June 24, 1604. Built on seven hills clustered about the mouth of the river stands the Loyalist city which shares the name of the mighty flood whose waters tumble into the Bay of Fundy over the Reversing Falls.

Impassive as a sphinx, unchanging as the stars which have mirrored themselves upon its surface since the first night followed the first day, the mighty river has flowed, unheeding the changing scenes of human struggle which have unfolded themselves upon its shores. The exact date of the first appearance of the white man in the harbour is not known, but as early as the opening of the sixteenth century hardy Basque, Breton and Norman fishermen had ventured into the Bay of Fundy. Finding the Indians friendly and willing to barter their furs for the merest trinkets, the fishers made further visits and during this century the trade with the Indians grew to quite appreciable proportions.

Entering the harbour, Samuel de Champlain and the Sieur de Monts, by giving the river the name of the Saint, commenced the first authentic history of the Saint John river. Three disastrous winters discouraged their hope of colonisation and friendly savages watched the two little vessels disappear over the eastern horizon, only to reappear three years later when Poutrincourt, with renewed zeal for adventure, returned to Port Royal.

Meanwhile the traders of St. Malo and Rochelle established themselves on the island, Emenenic, the Long Beach of the Saint John, and these having shown disregard of Poutrincourt's monopoly, Biencourt, son of Poutrincourt, decided to exact their submission, but returned to Port

Royal after having established the best of feelings with Captain Merveille, commandant of the island settlement. Following the capture of Port Royal, for the English in 1613, Acadia was not restored to France until 1632, by the Treaty of St. Germain.

The sack of Port Royal in 1613 had driven young Charles la Tour to a life among the Indians and only his diplomacy saved him from spending his days as a savage. During the war between England and France, 1627-29, he obtained from Louis XIII a commission as lieutenant-general and at the same time he secured from Sir Wm. Alexander the title of baronet of Nova Scotia. Having obtained a grant on the lower Saint John he erected and fortified his headquarters on the harbour at the river mouth. In 1635, d'Aunay Charnisay, having been placed in command of Acadia following the Treaty, and La Tour, found that through bungling on the part of the government in France, their respective territories were defined so that each included the stronghold of the other, a situation not likely to augur well for peace betwixt two men, both of whom were possessed of more ambition than forbearance. Charnisay repaired to France where he secured five vessels and the service of five hundred soldiers. Meanwhile La Tour was not idle—through personal accumulation of an armed vessel, ammunition, supplies and one hundred and fifty soldiers together with aid from Boston, he was able to recapture Port Royal and relieve his own fortress. Charnisay was determined—his frequent attacks resulting finally in the capture of the Fort and death of Lady la Tour, while its commander was absent. When, in 1651, La Tour, returning to those scenes from which he had been twice exiled, and finding himself re-instated in Saint John as lieutenant-

general of Acadia, has shown himself to have been more the realist than the romanticist. He swiftly solved a dispute concerning claims of Charnisay's widow (Charnisay having been drowned shortly after the capture of Fort la Tour) by marrying her. A year later, when ships commanded by New Englanders from Massachusetts and supplied by Oliver Cromwell, faced the garrison, La Tour surrendered his fort—but not his claims. Being a clever diplomat, by placing his claims before Cromwell, La Tour succeeded in obtaining, with two others, Thomas Temple and William Crowne, a grant for nearly

all Acadia, after which he sold his rights and retired to private life. He died in 1663, and his ashes rest in the soil of his loved Acadia.

Perhaps readers of this narrative whose words do poor justice to its theme will condemn and say that this has not been a history of a mighty river but only that of a few men who touched its shores. Rather it exemplifies upon its eternal surface the essence of all history. Ever the ripples rise and fall, surge and break, but even in that rise and fall, in that ceaseless change which yet changes not, consist the eternal sameness which only the river understands.

Miss Edna M. Auger

By the death of Edna Mabel Auger the nursing profession has lost one of those most active in nursing education, especially in its development in the province of Alberta.

Miss Auger died at the Medicine Hat General Hospital on May 2nd, following an attack of pneumonia, with complications.

Daughter of a family of Western pioneers and graduate of the School of Nursing, Medicine Hat General Hospital, 1906, where most of her years since then have been spent, Miss Auger was chosen by the nurses of Alberta to represent that province when the History of Nursing Society of the School for Graduate Nurses, McGill University, published the historical pamphlet, *Pioneers of Nursing in Canada*.

Awarded the gold medal of her year, she became charge nurse in the operating room previous to going to New York, where three years were spent in the operating room at Dr. Bull's private hospital. While in New York, Miss Auger studied dietetics at Teachers College, Columbia University. Called back to Medicine Hat, she became assistant superintendent and instructor of nurses. This work was interrupted when she resigned in 1915 to join the Canadian Army Medical Corps Nursing Service. The greater part of four years was spent

in France and Belgium, at No. 1 Canadian General Hospital, at Étaples, No. 1 Canadian Casualty Clearing Station, No. 3 Canadian General Station, Boulogne, and No. 9 Canadian General at Moore Barracks and Rhyl, Wales. She had the privilege and honour of receiving the Royal Red Cross from His Majesty King George.

Upon return to Canada and after a year's rest, Miss Auger went to Grande Prairie in the Peace River district to help organise the local cottage hospital under the municipalities. In 1922 she resigned that position to take over the duties of Superintendent of Nurses at the Medicine Hat General Hospital, which position she held until her death.

Deeply interested and active in provincial nursing affairs, Miss Auger served continuously as a member of the Council of the Alberta Association of Registered Nurses, and for the greater part of the time she was Chairman of the Nursing Education Section. The nurses of Alberta will miss very much her sane and progressive judgment, especially needed in future, as the Alberta Association of Registered Nurses receives the co-operation and assistance of the Senate of the University of Alberta in the development and advancement of nursing education.

Report of Unemployment Among Nurses in Alberta

[NOTE: At the annual meeting of the Alberta Association of Registered Nurses, Miss Phillipa Chapman gave a report on the unemployment situation among nurses in Alberta. This report is published verbatim.]

The year of 1931, just passed, will go down in our memories as one of the blackest. We hear the words "Depression and Unemployment" every day until we are weary of the sound of them. Probably none is unaffected by their reality. In our own profession, the private duty nurses feel it the most, as their ranks are swelled by nurses who formerly had regular employment in doctors' offices, etc., and by the ever-increasing number of new graduates and by nurses returning from the United States, where they had employment and in many cases fine positions, and now have been squeezed out by the natural demand of the American nurses that they be given the preference. I should like to voice here appreciation for what is being done by some hospitals to cope with the situation. One institution is giving one week's holiday without pay, but with meals provided, to its general duty graduates, and is employing several extra graduates this way. Another institution aids its young nurses, who having completed their training periods, have not graduated. They are permitted to stay on at the hospital and are given a small salary and if possible a "special" case. Though the remuneration is low, this is very helpful, for as every private duty nurse knows, regularity and permanence of income are very desirable, making for freedom from worry and apprehension as to future prospects.

Unemployment among private duty nurses does not seem relieved, and it was hardly anticipated that it would be during the past winter. In view of this fact, that is, that this condition may continue for some time, the Edmonton Association of Graduate Nurses anticipated calls for assist-

ance by nurses seriously embarrassed financially, and the Mutual Benefit and Loan Fund was raised. The appeal for funds met with a very generous response, and a substantial sum was collected. It was contributed to by salaried nurses in the main; that is, institutional, public health and V.O.N., and also by a few of the more fortunate of the private duty nurses, although they were not canvassed for subscriptions. It was felt that private duty nurses would be more likely to be in need of assistance, but only two applications have been received, one from a private duty nurse and one from a hospital employee.

Considering the tightening of money, it is somewhat surprising that we have encountered very little actual distress, but perhaps nurses are reserved about telling the world of their difficulties. We hear sometimes of one here and there who has valiantly risen to the occasion and is trying to make the best of things by working in a store, or café, or doing housework.

After having read Dr. Weir's report, we are brought to a fuller appreciation of the evidently unsatisfactory state of nursing affairs, and this gives us much food for thought. Perhaps a system can be gradually worked out to put nursing services within the reach of more people. A few of Dr. Weir's suggestions are: "Higher standard of education for the graduate nurse. Hourly nursing; group nursing, and employment of more graduate nurses in hospitals, and a system of State Health Insurance," which latter is already a project of the present session of the Legislature of the province of Alberta.

In conclusion, let us hope that the clouds of depression and worry will soon be blown away, and the sun of prosperity shine again. Whatever the future holds, the nursing profession has proved it can meet it with courage, and a singular lack of complaint. For the Private Duty Section, we hope for a bigger and better year.

Department of Nursing Education

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A Suggested Plan of Health Service for a Hospital and School of Nursing Personnel

By MARION LINDEBURGH, Assistant Director, Teaching in Schools of Nursing,
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HEALTH SERVICE FOR STUDENT AND GRADUATE NURSES

There yet remains for discussion a plan of health service to be adapted to the needs of students and graduates in the Department of Nursing. From the hospital point of view the general objectives would be the same for this particular department as for other hospital departments. One significant factor that should emphasize the outstanding need of health for nurses is in the fact that the nurse comes in closer and more continuous contact with the patient than any other member of the hospital personnel. The correlation between physical and mental health and nursing efficiency cannot be overestimated.

Many factors in the maintenance of health in the student body, is more directly the responsibility of the principal of the nursing school, than the superintendent of the hospital, but it is only through more favourable living and working conditions, to be provided by the hospital administration, that the director of nurses can set up and maintain an effective health service for student nurses. This has been, and is today, a very vital issue in the whole problem of Nursing Education. The health of the student nurse cannot be given its fullest consideration until the plan of education in its relation to hospital nursing service is adjusted to a very considerable degree.

A health office should be provided in the nurses' residence and a competent graduate nurse who has had a graduate course in Health Education would be the desired director.

Every student should have a complete health examination upon entering the school. In this connection the services of a doctor will be required. Should a student's condition be such as to indicate her inability to undertake the course she should not be accepted. This aspect of a health service is a well-established function in many nursing schools, and its value is fully recognised.

An immunisation programme has been undertaken in nursing schools for some time, and because of the youth of some of the students entering the schools today, immunisation against scarlet fever is also being provided.

A very important function of a health service for student nurses should be a plan of supervision throughout their period of education. Correction of dental and visual defects should be imperative. Through weight scores and periodic health examination an index of the students' health should be available at any time. The following extract from a nursing journal suggests a situation deserving of serious consideration. "It is a well known fact that certain life assurance companies have discontinued the granting of disability

benefits to nurses. It has been shown that the incident of tuberculosis in student nurses is one-third higher than in other women of the general population."

The hospital and the school of nursing have a very definite responsibility in this matter of student health. From the hospital point of view, it is good business to keep up a high standard of personal health among nursing members, but the nursing school has a greater and a moral obligation to fulfill to the students: firstly, as individual members of society; secondly, in their development for professional service—in which health is a fundamental requirement. The very nature of the nursing activity, with its present-day emphasis on health teaching, is sufficient to indicate the importance of health as a part of the professional equipment of every nurse. She should be able to demonstrate in appearance and in practice, that which she is attempting to teach. To recognise that health is of meaning and significance—not as an isolated end in itself but in relation to other life values, is of tremendous importance today. Professor Bonser, of Columbia University, in an address, "An Educational Perspective," says, "It is my philosophy that the purposes of life, health and education are one. In the long run efficiency, satisfaction and enjoyment all depend upon the healthful functioning of body and mind. Health is a factor which affects our thinking, our feelings, and our acting—our behaviour in waking or sleeping, not less than one hundred per cent. of the time."

In order that healthful attitudes and ideals may become an integral

part of the personality of the nurse, it is very essential that the health director possess a personality sufficient to gain the full confidence of the students. They should feel free to confer with her at any time. In the Bellevue nursing school in New York City, where a very successful health programme is in operation, the graduate nurse who has charge of the health of the students also teaches the course in Health Education. This is most commendable in that her interest, understanding and contact with the students in the health office establishes that *rapprochement* which is so necessary for effective teaching and learning.

For many reasons it is appropriate that the health director also be in charge or have supervision of, the nurses' infirmary. If she is a person truly interested in the welfare of the students, giving spontaneously of her time and effort and making her presence and services of indispensable value, it is to be recognised that she is performing a full time function.

In conclusion it might be said that "a hospital cannot be separated from the problem of health." It carries a responsibility not only to its patients, but to all its employees and to the school of nursing. The hospital, however, can but set up the machinery whereby health may be maintained. Its fullest function can only be secured through the co-operation of all departments and through the recognition of the health service as a valuable facility, of which all should take advantage.

NOTE: Part One of this paper, dealing with the Health Service of a Hospital Personnel, was published in the May issue of the Journal.

Announcement was made in the May number of the *Journal* that an address by Dr. A. T. Bazin, of Montreal, dealing with the Survey Report would be published in this issue. In view of discussion of the Survey Report at the General Meeting of the Canadian Nurses Association, June 21-25, 1932, the Publications Committee has decided that Dr. Bazin's address be not published previous to that meeting.—The Editor.

In Consideration of the Small Hospital School of Nursing After Reading the Survey Report

By C. E. GUILLOD, Superintendent, Maple Creek General Hospital, Maple Creek, Sask.

As a small school of nursing executive the writer can safely say that occasionally at least the town or small city provides a community background and social life suitable to the needs of the small school. The matter of the size of the hospital permitted to retain schools of nursing will rest with the large hospitals, which hitherto have been generous in granting affiliations, as no small hospital can of itself provide the variety of clinical experience necessary. While it is much easier to teach in the classroom of the large hospital where there is a fully equipped teaching unit, the writer has found it easier to correlate theory and practical work in the small hospital. It often happens that a nurse who has trained in a school in connection with a small hospital and had part of her training in affiliation in larger schools is less insular than one who graduates from a hospital of 100 or 200 beds. Also, she may be more adaptable and more ready to nurse all types of cases, especially in the rural districts, than is the graduate of a large hospital. The small hospital does inculcate a love of nursing. There is bound to be keener interest in a patient whose illness is followed by the student from admission to discharge.

It is most necessary that the personnel of the teaching staff be all that could be desired in the matter of personal influence, as well as fitness from an educational standpoint, and it is certain that executives will have to be drawn from the largest schools.

Problems which may have to be considered in the small hospital school of nursing are: that boards are not always sufficiently versed in

the qualifications required in those who instruct; that qualified instructors do not care for smaller communities; and that the equipment of the hospital for making physical examinations of the student is not adequate. On the other hand, the student receives a good deal of personal supervision and care that are more difficult to give in the larger hospital.

Before deciding that the small school has no contribution to make toward nursing, it must be considered whether the small hospital can meet the local needs of the community without employing under-graduate staff. There are too many graduates from schools of all sizes who feel free on graduation to regard social life as of more importance than professional duty, when they find themselves away from the restrictions of school life. Unfortunately the small community encourages this freedom.

The number of nurses graduating from a small school and remaining in the nursing field is more or less negligible often, because so many use their training only as a preparation for a larger vocation in life. The small school should not be allowed to exist if in so doing it lowers the standard of all training schools. In the writer's opinion the development of the personality of the student nurse is of more importance than the size of the hospital where she receives her training. Her ideals are so much influenced by the vision of her instructors that the personnel of the teaching staff—both doctors and nurse instructors—is of the utmost importance.

Let us hope that nursing will not become less of a true art in the zeal for perfecting the mechanism of nurse education.

Department of Private Duty Nursing

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What of the Future?

By E. PODEEN WILLIAMS, Hamilton, Ont.

In contemplating the details of our own future most of us "See through a glass—darkly." We vaguely picture the final years of life in surroundings probably similar to or even better than those we enjoy today.

Such a pleasant vision may lull us into a false sense of security. Look at the matter from the point of view of other people's experience. Each one of us has, in our circle of acquaintances, at least one elderly nurse who must pass the remaining days of life scraping along on an insufficient income.

These women at one time lived comfortably and felt independent and self-reliant. They enjoyed a good income and were self-supporting. Now independence has become dependence. Why? Because they did not make adequate provision during their working years for the inevitable period when they could not obtain remunerative employment. Life can become burdensome if the "Sunset years" are empty of all good and pleasant things. It is better to forego some luxury early in life than to be left without means of ordinary subsistence later on.

The problem of old age independence is primarily a personal one. We must each find a personal solution. In common with every other achievement a successful old age income provision can result only from a sound pre-arranged plan, carried through in a determined manner. Such a plan must be decided upon

and put into operation when we are at the height of our career. Delay is dangerous. If life may last far beyond our income-producing years then our problem is to accumulate enough capital during those working years to provide an income when we are old—for then we still must live though we have no earned income.

Take a pencil and a piece of paper and do your own figuring. Bear in mind the added leisure which will be yours after retirement, allow for basic living expenses and any contemplated luxury, then fix the amount of monthly income you will require. If you happen to be one of those few lucky people holding a position which entitles you to a pension, deduct the pension from your estimated retirement income (but please remember that a professional pension is rarely enough in itself)—don't let the fact that you may get such pensions lead you away from further consideration of your old age income problem.

Then put that pension on a yearly basis—how much money will you need at retiring age to *guarantee* that income for say 10 years, 15 years or 20 years? You can approximate this figure easily. Now, how much will you need to guarantee that income to last as long as you do? This is really a difficult question. You can't afford to take a chance on your capital running out if you live to extreme old age. If you can solve this last problem you must still decide on a savings plan, you must

know how much to put away each year and you are even then faced with the safe investment of our savings until retirement age is reached.

Thus you will see three main elements which must be present in your income plan:

- (1) A definite savings scheme.
- (2) Safe investment of the money saved.
- (3) Some guarantee that the fund saved will be sufficient to provide an income as long as you live.

Being nurses and not financial experts these seem to be insuperable difficulties. It has, however, been my privilege to find a solution to this apparently difficult problem in a way which takes complete care of the three elements quoted above. The beauty of my solution is that the whole matter is all arranged in one simple contract. I am passing this solution on to you. I find that most insurance companies have a Pension Investment Bond or a Deferred Annuity Contract which will provide complete retirement income service in the simplest way. For a fixed annual deposit made between the present time and the time you intend to retire, a guaranteed monthly income will be paid from the time of your retirement. This income is absolutely guaranteed as long as you live. The insurance company assumes the responsibility of paying your income regularly month by month. The annual deposit is fixed and measures the limit of your obligation. You have every incentive to save; the necessary element of compulsion is

present. You have no investment difficulties. You are not exposed to the risk of loss which is attendant upon individual investment. Your bond and hence your future is financially guaranteed by the total assets of the insurance company. In addition to these benefits the return from a pension bond is as good as that you could earn on any first-class investment of your own selection.

These bonds are designed to provide an individual solution to every retirement income problem. There are certain variations and certain additional features which when properly combined will adapt the bond to your own particular need. If you have dependents they can be protected if you feel you ought to provide for them.

In your own interests I would ask each one of you to determine the income you will require after you have retired. Consult an insurance man as to just what deposit will be required from you to guarantee the pension you have fixed. Make that yearly deposit your first responsibility. This is not an expense—it is a saving in every sense of the word. It is the least you can do to help that old woman you will become. Budget for your deposit month by month. You will be surprised how easily you can save the necessary money. Buy such a bond and you will really be delighted to find how much happier you will be, how much more content you will be and how much more enjoyment you will get out of spending the remainder of your income knowing that your future financial independence is absolutely guaranteed.

Department of Public Health Nursing

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*The Nurse's Place in Industrial Health**

By WILLIAM A. SAWYER, M.D., Medical Director, Eastman Kodak Company,
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When a graduate nurse enters the public health field, and particularly the industrial nursing field, a new opportunity presents itself, for here emphasis is being placed on keeping the so-called well people well, thus preventing much needless disease and disability. Here health is a positive thing, and its maintenance, by avoiding sickness, is the goal. In industry we deal for the most part with so-called well people, endeavouring to educate them to better ways of living by taking care of little ailments or defects before they become serious. Here we see disease in its earliest beginnings, much earlier than a nurse ever saw it in the hospital or in private duty work.

In the examinations of applicants for work, the nurse has her first contact with the worker. If she is doing her task in the best "human relations" fashion, she will want to make this rather trying experience as pleasant and profitable as possible for the employee. Usually the nurse makes the preliminary tests and records some of the history. By her manner she can put the individual at ease, secure from him truthful information and lay the foundation for future happy relations. Later when this employee is seen about correcting the

physical defects found, the nurse again exerts her good influence in explaining the importance of having such things taken care of. Teeth, tonsils, eyesight, weight, blood pressure, habits, etc., are all deserving of attention. It is an educational and confidential adviser's job. I have seen nurses take great delight in getting an individual to do things that everyone knew were necessary and wise. Overcoming natural resistance due to fears or ignorance, sometimes due to cost, is always a victory that gives a thrill—if she is interested in people sufficiently and has the patience to labour with them sympathetically and forcefully. This sort of thing is not what the nurse learned to do in the hospital while in training, but it is a thing for which her training and previous experience in the hospital were a splendid background. With it she should have an understanding and appreciation of human tendencies and weaknesses which enable her to handle effectively the many individual problems which confront her.

Attitude Toward the Job

It is the practice in industry to have employees go to the nurse with all manner of small complaints and ailments—very insignificant things she may think at first, but really most important because, as she sees these same people again and again, she will come to realise that here are the po-

(*From "Public Health Nursing" and published by courtesy of the Secretariat of the League of Red Cross Societies.)

tentialities of what later may become very big and serious difficulties. We all know that most people do not visit the doctor until they are really sick and they seldom have a chance to see a nurse unless it is in the hospital. It costs good money to go to the doctor, and naturally it's an expense to be avoided as long as possible. But in industry, if someone comes to the nurse repeatedly for a headache remedy, she will make inquiry, refer him to a private doctor to have that headache, which is a warning signal, investigated. No telling what may be avoided by correcting the cause. It may be an ailment small now, but a thing which may eventually lay down the wage-earner of a family. Again and again the nurse will have many opportunities to advise, to teach and counsel. It is really so much more satisfying than just patching up one who is oftentimes beyond real permanent help.

In the treatment of those injured at work, the nurse, of course, experiences the sort of work she saw in the hospital, but even here a new attitude is apparent. Effort made to bolster up the mental attitude often prevents disability of the mind. Dr. Foster Kennedy, of New York City, has drawn attention to the well-known fact that the amount of trauma is no measure of neurosis which may develop. Oftentimes the less the trauma the greater the neurosis. We must remember that many times workers are more solicitous about their jobs than about their health. Either because of wrong handling at the start, unwise remarks by the doctor or nurse, or because the one injured is inherently susceptible to such end results, these unfortunate cases develop. By prudent sympathy, constantly keeping in mind the return of the injured one to a good functional working capacity in a reasonable time, taking advantage of occupational therapy and rehabilitation procedures, the disability may be shortened and ultimate cure made more certain and prompt. Here massage, baking and other phy-

sical therapy give the nurse her great chance to see what first seems a hopeless invalid changed to a completely rehabilitated individual. Repeatedly I have seen cases come around in a most miraculous manner, due entirely, I believe, to the mental attitude and determination of the nurse. Oftentimes the personality and whole emotional slant of such individuals are changed. They are less fearful, more self-reliant, neater about their person and always loyal supporters of the medical work. This surely is glorious achievement. Here the doctor is helpless without the right nurse.

Perhaps the nurse in industry may find herself in a home-visiting position or it may be a combination of inside and outside work. In a visiting position she takes on more of the attributes of a social worker—certainly she is the better fitted to tackle such a job if she has at least an understanding, or better still, some actual training or experience in social case work before she goes into industry. Usually the visiting does not include bedside nursing. It is chiefly a friendly call to determine how sick the worker is and what advice may be given in assisting the worker to get back to health and his job. Here, rare diplomacy coupled with keen insight and analysis of the situation are the requisites. It is no simple door-knocking and "how-do-you-do" job, but one in which some knowledge of psychiatry and psychology both play a part. Many important situations arise, calling for tact, discernment and sound advice. Here is an educational opportunity for the most avid.

Vitalising Routine

I know there are so-called finger wrapping jobs. I have seen them. I would not want to be aligned with such a situation nor would any progressive nurse, I am sure. Usually, however, most of these finger wrapping jobs can be developed into something more. Even when a nurse is but one of a large staff and only does dressings of one kind, she can make of her job, I believe, something more

than a purely mechanical, repetitive task. If she is interested in those people she does things for, believes in herself and the cause for which she labours, and has something more than the average person's understanding of life, she will begin to see the pleasure and value in just a friendly smile or a cheery word. Nurses often make reputations on such things, and a pleasant personality alone puts her above the average. Added to this, a query about the job, the family or their health, with a sage bit of advice, or any one of a dozen things, such as an explanation of why one should

care for his health or why one should drink more water or get more sleep—and you have indeed raised a hum-drum thing to a calling. The nurse who finds zest in her work is one who is constantly trying to solve the riddles of life, who reads voraciously of the things that enlarge her vision and sphere of understanding, and who in time finds satisfaction and value in transmitting some of this to those less fortunate. Is this more than private duty care of the sick; is it more than most public health jobs? It is something definite and concrete—a programme which conserves and builds.

Radio Health Talks

The following is one of the many appreciative messages received by the Department of Health and Public Welfare of Manitoba from a public health nurse:

"During a recent visit to Birtle and district, I accompanied Miss —— to every home in the municipality, and was much interested to find the number of people who were 'listening in' to the radio health talks as given by the Department of Health and Public Welfare. They were, without exception, unanimous in their praise of the value of these talks.

"In one instance we had much difficulty in obtaining an answer to a rap at the door. When finally the lady of the house did appear, she said: 'The health talk is going on and I feel I need to get all the advice I can on my health, so I just sit down

and drink it in.' We crossed the road to the next house to give the first lady an opportunity to finish 'drinking' the health talk. There we found it the same. The family were seated at the dinner table, listening to the health talk. Miss —— and I decided we might just as well take the noon hour off on Tuesdays and Fridays as the people were all too engrossed in the health talks to admit callers.

"From my experience in the rural districts, I would say that the radio has been responsible for at least fifty per cent. of the publicity given the Department of Health and Public Welfare, and hope that this very valuable means of education may be continued, particularly for the benefit of those in the more remote parts of the province."

Nova Scotia—Its Possibilities for Vacationists

The natural Ocean Playground known as Nova Scotia is a magnet to beauty lovers, who journey thither, year by year, in constantly increasing numbers. Many of these drive their cars in overland. Others have their cars conveyed to the province by steamer from Saint John, New Brunswick; from Boston; from New York, and from Philadelphia.

The motorist who drives his car into Nova Scotia overland crosses the Missaquash River, which separates Nova Scotia from her sister province of New Brunswick, and traverses the famous Tantramar marshes to Amherst. In the neighbourhood are the grass-crested mounds of two famous forts—Lawrence and Beausejour—relics of the titanic struggle between France and Great Britain for the mastery of North America. The embankments and entrenchments are still to be seen and attract an increasing number of history lovers year by year. Each motor route has distinctive charms all its own. A short route to Cape Breton Island is by way of Amherst and New Glasgow, along the attractive gulf shore of Nova Scotia, where there is excellent boating and warm salt water bathing, together with bracing sea air, sport fishing and bird shooting. This district was early peopled by settlers from the old colony of New York, who, in 1784, sought refuge here after the War of Independence.

Salt mines are found in the peninsula of Malagash: the deposit of pure white salt here is estimated at 25,000,000 available tons.

Parrsboro is a popular resort on the Basin of Minas, waters celebrated in legend and song, with good fishing and shooting in the neighbourhood. From here a steamer makes daily trips across the Minas Basin to Wolfville in the heart of the Evangeline country.

Truro, settled by New Englanders, a railway divisional point and the seat of several educational institutions, is situated in one of the outstanding farming regions of Canada. The Agricultural College and Farm are well worth a visit, and a wide range of entertainment is offered by numerous sport and athletic clubs. Victoria Park is a magnificent natural playground of 1,000 acres, with a picturesque waterfall.

From Truro, across the beautiful valleys of the Stewiacke and Shubenacadie rivers the road sweeps to the Grand Lake district, then past the lovely Waverley lakes into a wooded country, emerging on a hill overlooking the magnificent Bedford Basin, which forms a portion of the harbour of Halifax, one of the finest in the world.

The old-world city of Halifax, with its impressive Citadel and lovely North West Arm, has an individuality all its own. The historic Province House, often spoken of as the finest specimen of the Georgian type of architecture on the continent, contains many valuable portraits and relics of interest. The Public Gardens, founded in 1753, are famed for their beauty. In St. Paul's Church, the oldest Protestant Church in Canada, are interred many men distinguished in the history of Canada. Numerous interesting historic sites throughout the city have been marked with tablets by the Nova Scotia Historical Society. There are four golf courses in the vicinity—three of them 18-hole courses—offering a wide variety of attractions, with magnificent vistas, rolling surfaces and an abundance of natural hazards.

All lovers of the beautiful revel in the bays along the south coast line. There is Saint Margaret's, so named by Champlain; Chester, Mahone, Liverpool, Jordan and Barrington.

These bays sweep deeply inland, with curving sand beaches, while mysterious wooded islands lie off-shore. Farther on is Lunenburg, one of the greatest fishing ports of the continent.

At Fort Point, on La Have River, known as the "Rhine of Nova Scotia," may be seen the remains of a French fort, erected in 1632. The view from the hills is one of the most memorable in Nova Scotia. Within easy reach of Liverpool, which occupies the site of an ancient Indian village, are four splendid sand beaches. During the American Revolution and also during the war of 1812, privateers were fitted out at this port and brought back stores of wealth. From Liverpool through glistening white sand dunes to Port Mouton one comes to Shelburne, situated on an elevated plateau overlooking one of the finest land-locked harbours. Founded by citizens of New York City after the War of Independence, Shelburne is redolent of historic lore, and a noted fishing and ship-building centre.

Yarmouth, one of the principal entry points of Nova Scotia, is only a few hours from Boston. It is a charming town, with old English hawthorn hedges and a broad and pleasing harbour. In Acadian villages that border for thirty miles the shore of Saint Mary's Bay one may discover some of the old customs, a few of the costumes, and much of the old Acadian speech of Evangeline days.

Near the mouth of Annapolis Basin is the famous summer resort known as Digby, with a daily ferry steamer to Saint John, New Brunswick, which carries cars. Nearby is Bear River, a most picturesque place and known as the Switzerland of Nova Scotia, and Digby Neck, with the rolling hills and nestling villages with their feet in the blue waters of Saint Mary's Bay.

Along the Annapolis Basin—a long and strangely beautiful body of water, is the historic town of Annapolis Royal, founded in 1604,

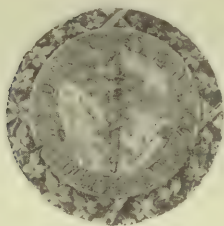
the oldest town north of the Gulf of Mexico. Here is Fort Anne, steeped in romance, which has been set aside by the Dominion Government as a National Park. A fine view of the ramparts is found on the golf course, with the wooded slopes of the North Mountain as a background. Here, too, is the famous Annapolis Valley, one of the great apple-growing countries of the world. Two million barrels of apples were grown there last year, and as yet not more than twenty per cent. of the land suitable to apples has been set out to trees. In the springtime there are one hundred miles of white and pink blossoms—a world of bewildering beauty that holds the observer spellbound.

Further on is Grand Pre, known to every schoolboy and school girl. Thousands of visitors from all over the world visit Grand Pre every year in order to see the treasure house of Acadian memorials which has been established there.

Windsor is the chief centre of Hants County and combines the advantages of a modern shipping port with the charm of the old world town. The phenomenal tides of the Bay of Fundy, rising to forty feet at flood, may be seen here to advantage.

From New Glasgow one passes inland through an interesting farming country to Antigonish—a university town—beautifully situated amidst immense shade trees and surrounded by high hills. Farther on lies the Strait of Canso, on which a modern motor ferry conveys tourists to Cape Breton Island. On the shores of the wonderful Bras d'Or Lakes is Sydney, one of the great steel-making centres of Canada, also Louisburg, with its dramatic and tragic history, which exerts a subtle yet powerful influence upon the mind of the visitor.

Baddeck, one of the world's gems, is found in the historic Island of Bouladerie. The Bras d'Or Lakes, on which the town is situated, are inland sea lakes, practically tideless and of great beauty.



Canadian Nurses Association

By the time this issue of the *Journal* reaches the nurses, the federated associations will have named official representatives to the Sixteenth General Meeting of the Canadian Nurses Association.

The total number of delegates from these associations is sixty-eight. According to the by-laws of the C.N.A. each organisation is entitled to one vote for every fifty members until the maximum of ten votes is reached. Four provincial associations have reached the maximum number of votes, three others have a membership giving them seven votes, one has six and one has one vote.

All members, including delegates, are asked to arrive in Saint John so that they may be present for the opening business session, which is scheduled to commence at 9.30 o'clock on Tuesday morning, June 21st. The business of the C.N.A. will be continued into the afternoon session, while in the evening at an open meeting the C.N.A. will receive its official welcome to New Brunswick, and the Hon. Vincent Massey will give an address on "The Public and the Survey Report." This brief outline is sufficient proof for stressing that all nurses arrange to reach Saint John previous to the first session.

The Executive Committee, the officers, the chairmen of sections, and four councillors from each provincial

association are expected to attend meetings of the Executive Committee, C.N.A., as well as those of the Sections. The latter open at 1.30 o'clock on Monday afternoon, June 20th, with the general Executive at 2.30 p.m.

As previously announced, the Report of the Survey of Nursing Education will be the subject for discussion by nurses at three sessions, i.e., Wednesday morning and afternoon and Friday afternoon. The point of view of the scientist, the educationist and the medical profession in regard to the Report will be interpreted following the banquet on Wednesday, and on Friday evening.

The Sections will meet concurrently on Thursday afternoon and Friday morning. The final general business session takes place on Saturday morning, followed by the Executive Committee meeting in the afternoon.

Interspersed throughout the week there will be opportunities for social relaxation arranged by the New Brunswick Association of Registered Nurses, when visiting nurses will enjoy the hospitality for which the people of the Maritimes are renowned.

The Admiral Beatty Hotel will be headquarters for the Canadian Nurses Association for convention week. The management assures excellent accommodation for all sessions and for the comfort of the nurses as guests. Reservations should be made at once if not already procured.

*Canadian Nurses Association**NOMINATION TICKET, 1932*

- For President:* Miss Florence H. M. Emory, Assistant Director, Department of Nursing, University of Toronto, Toronto.
- For First Vice-President:* Miss Ruby M. Simpson, Director, Public Health Service for Saskatchewan, Regina, Sask.
Miss Mildred Reid, Practical Instructor of Bacteriology, Manitoba Medical School, Winnipeg, Man.
- For Second Vice-President:* Miss Gertrude M. Bennett, Superintendent, School of Nursing, Ottawa Civic Hospital, Ottawa, Ont.
Miss Margaret Kerr, Assistant Director of Nursing, University of British Columbia, Vancouver, B.C.
Miss A. J. MacMaster, Superintendent, Moncton General Hospital, Moncton, N.B.
- For Honorary Secretary:* Miss Nora Moore, Department of Public Health Nursing, Toronto, Ont.
- For Honorary Treasurer:* Miss Margaret Murdoch, Superintendent, School of Nursing, Saint John General Hospital, Saint John, N.B.
Miss Kathleen Sanderson, Executive Secretary, Greater Vancouver Health League, Vancouver, B.C.
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For Programme, in detail, of the General Meeting, see the May number of the *Journal*.



Courtesy, Canadian National Railways

Bras d'Or Lakes, Cape Breton.

Report of Annual Meeting—British Columbia

The annual meeting of the British Columbia Graduate Nurses Association was held on March 29th, at St. Paul's Hospital, Vancouver. Interesting meetings were held throughout the day.

During the morning, round table conferences were held by the various sections: Nursing Education, Public Health and Private Duty.

A discussion of "Curriculum Problems," led by Miss Grace Fairley, took place at the Nursing Education Section, following which resolutions dealing with important nursing education problems were drafted to be presented at the general meeting.

Miss Laura Holland, Deputy Provincial Superintendent of Neglected Children, was the speaker at the Public Health Section; her subject being "Co-operation of the Department of Neglected Children." Following the address a general discussion took place.

At the round table discussion of the Private Duty Section the subject was "The Unemployment Situation," led by Miss Mirfield. Time was spent in preparing the report to be presented at the C.N.A. Convention.

At 11.30 a.m. a meeting of the council was held.

At 2 p.m. the general meeting was called to order, Miss Mary Campbell, the president, in the chair. The invocation was led by Rev. Father A. F. Griffith, following which Miss Campbell presented her report for the year. She stressed the need for study groups and sustained interest in the Survey Report if results were to be brought about.

Miss Dutton, secretary, gave her report and also read a synopsis of council meetings held throughout the year.

Miss H. Randal, Provincial Registrar and Inspector of Training Schools, was unable, through illness,

to be present, and in her absence her reports were read by Miss Mabel Gray.

Reports from the Nursing Education Section were presented by Miss Gray, convener, and three resolutions were read for which the approval of the meeting was asked.

On the completion of the business, the meeting adjourned to the reception room of the Nurses Residence, where tea was served by the combined Alumnae Associations of St. Paul's Hospital and the Vancouver General Hospital.

Business at the evening session included the reading of the report of the Public Health Section, by Miss Kerr, convener. A proposal from this section for the Association to place two copies of Dr. Weir's Survey Report on the open shelf of the Provincial Library in Victoria was adopted.

The Association was privileged in having two interesting speakers: Miss Jean Browne, Director of the Junior Red Cross, spoke briefly on the enrolment of nurses for emergency service and said that up to the present a total of 576 registered nurses had enrolled.

Dr. George Weir, Director of the Survey of Nursing Education in Canada, gave an extremely interesting address, taking as his subject "The Nursing Survey." "Private duty nursing must be socialised with the control remaining in the hands of the nurses," Dr. Weir affirmed. "Public health nurses today are an example of this type of control, and it is only a question of time until such a system is in operation throughout this country. At present there are 12,000 unemployed nurses in Canada and something must be done to remedy this situation. It is time that individuals should be forgotten in the interests of the masses, and one may

become community-minded without becoming communistic." The education of the student nurse was an important factor. The speaker expressed the opinion that in twenty-five years' time a university education would be considered quite as necessary as is a high school educa-

tion today, and that the requirements for entrance would be character and capacity rather than wealth and social position. Dr. Weir defined education as making changes in the individual and as being an aid to the acquiring of a lofty and sane idealism.

Book Reviews

Health on The Farm and in The Village:

A Review and Evaluation of the Cattaraugus County Health Demonstration with Special Reference to Its Lessons for Other Rural Areas, by C.E. A. Winslow, Dr. P.H.; pp. 267; The Macmillan Company, New York, 1931. Price, \$1.10.

The sub-title is a concise statement covering the scope and purpose of the book. In the Foreword the author explains the "what," "why," and "how" of his commission. The Technical Board of the Milbank Memorial Fund desired "an impartial and comprehensive survey of the seven years' experiment of the Cattaraugus County Demonstration with a view to summing up the lessons to be derived from this experience with regard to the general problem of adequate health service for the rural districts." Dr. Winslow's reason for undertaking the task ensures a high standard of fact-finding to be followed by a keen analysis of the data for their full meaning. The reason is "he conceives the problem of rural hygiene to be the most vital one in the entire field of public health."

Chapter I, Lessons of the Rural Health Demonstration, begins with a description of the area, "Cattaraugus County, New York State, is a highly typical rural county of the Northwestern United States. It has a fairly stable and homogeneous population of 72,000 persons, mainly of native stock, engaged chiefly in small industry and dairying. It is relatively prosperous . . . having an average per capita annual income of somewhat under \$900.00 but with a substantial proportion of its people living at a very low economic level." There are two cities in the county: Olean, with a population of 22,000, and Salamanca with 11,000 people.

The first evidence of a felt need in health matters as expressed in action on the part of the citizenry is recorded. Its growth and development are traced to the setting up of the Demonstration plan in 1923.

The type of organisation in Cattaraugus County differed widely from the so-called "standard" county health units. It con-

sisted of bureaus to deal with communicable diseases, tuberculosis, statistics, nursing, maternity, infancy and child hygiene. Sanitary engineering was the last activity to receive attention. The author considers this to have been an unwise delay.

A county school hygiene service, a campaign of popular education and a social service programme were also developed. An unofficial agency gave impetus to both of the latter.

In 1927 the total appropriation for public health work from all sources reached its peak at \$176,000. In 1929 it fell to \$160,000. This represents \$2.20 per capita, of which \$1.00 came from the county and its local units, 50 cents from the state and 70 cents from the Milbank Memorial Fund. Dr. Winslow estimates that \$175,000 or \$2.40 per capita would be necessary to cover certain gaps in the programme. In 1930 the County Board of Supervisors increased its appropriation by \$10,000, which entailed an equal increase in state aid.

Under the caption Outstanding Specific Achievements and Lessons of the Demonstration are discussed: The County Health Unit—"such development is economically justified by direct returns in the saving of human life;" School Health Service—"There may be better systems but the one in operation has worked well;" The Nursing Programme—"one of the most notable achievements of the demonstration has been the creation of a public health nursing service which, taken all in all, is probably unique in a rural area;" Tuberculosis Control—"It has proved case-finding machinery, clinic service, nursing service, and institutional facilities which . . . are on a par with those of the best cities and are, so far as the writer is aware, superior to those yet provided in any other rural area;" Nutrition Service—"The studies carried on in the county have contributed materially to our knowledge of dietary problems in rural areas and to the technique of dealing with such problems;" Care of Crippled Children; Statistical Studies and Social Service were important phases of the programme. The latter revealed "The extent of uncare for social needs of a rural population."

More lengthy discussion of the nursing service might be expected by readers of "The Canadian Nurse." However, the strength of this service, in the reviewer's opinion, is its complete integration with the County Health Department programme, and therein lies the difficulty in treating it as an entity, and keeping within the bounds of the allotted space.

The reader is reminded that a scientific approach to such a study is the only fair or constructive one. "It would be too much," we are told, "to expect that a project of the scope and character of the Cattaugus County Health Demonstration would do all its teaching through the presentation of positive results. The experience in the development of the health work in the county has resulted in certain conclusions, which for this particular area are drawn from negative results, but are leading to the avoidance of similar missteps in the development of programmes elsewhere."

"Health on The Farm and in The Village" offers much food for thought and, to no small extent, guidance to the rural public health administrator and executive. The style is interesting. The type is clear. There are a number of excellent illustrations and statistical tables. The index is detailed and complete, making subject reference easy. E. L. M.

History of Nursing in the Province of Quebec: by Maude E. Abbott, B.A., M.D.; 97 pages; 42 illustrations. Price, \$3.00. McGill University, Canada, 1931.

This book, written by Dr. Maude E. Abbott, who is a recognised authority on Medical and Nursing History, gives an excellent and most interesting account of the development of medicine in the old Province of Quebec, from the time of Jacques Cartier's voyages until the present

day. There are many topics presented. Pages 9-31 give a complete picture of Indian Medicine in Eastern Canada, Life among the First French Settlers, 1535-1608, Pioneer Physicians, The Rise of Early French Hospitals and Medical Legislation under the French Regime.

The reader is introduced to the manners, customs and social aspects of this period.

The latter part of the book (pages 32-89) deals with many interesting details concerning the development of Medical Teaching, Great Epidemics, Introduction of Anesthesia, History of the Care of the Insane, Quebec Hospitals Today, and Modern Progress in Movements in the Province of Quebec.

There is a very excellent account of The Origin of The Montreal General Hospital and the establishment of the Medical Faculties of McGill University, The University of Montreal and of Laval University, Quebec City. The reviewer recommends the book to all those interested in history, and particularly to doctors and nurses.

It is of undoubted value in the teaching of Nursing History. A copy of "The History of Medicine in the Province of Quebec" should be placed in the library of all Nursing Schools. M.B.

BOOKS RECEIVED

The Principles and Practice of Surgical Nursing, by C. D. Lockwood, A.B., M.D., F.A.C.S., in collaboration with Mildred E. Newton, B.S., R.N. Price, \$3.30.

Fundamentals in Massage, by Kathryn L. Jensen, R.N. Price, \$2.40.

A Textbook on Bacteriology, by K. L. Burdon, Sc.M., Ph.D. Price, \$3.30.

These books are published by The Macmillan Company of Canada, St. Martin's House, Toronto, Ont.

BIENNIAL CONVENTION—AMERICAN NURSES

The biennial convention of the American Nurses Association, the National League of Nursing Education and the National Association for Public Health Nursing, held in San Antonio, Texas, April 11 to 15, had an attendance of three thousand delegates.

Miss Elnora E. Thomson, Professor of Applied Sociology, University of Oregon, Portland, was selected president of the A.N.A.; Miss Effie J. Taylor, Professor of Psychiatric Nursing, Yale University, New Haven, Conn., as President of the N.L.N.E.; and Miss Sophie C. Nelson, Director, Visiting Nurse Service,

John Hanock Life Insurance Company, Boston, as President of the N.O.P.H.N.

The Saunders medal awarded annually to the nurse who has given the most distinguished service to her profession was awarded to Miss Annie W. Goodrich, Dean, Yale University School of Nursing.

The house of delegates decided in favour of the N.L.N.E. as the educational department of the A.N.A., with no change in the structure or autonomy of the league.

The 1934 meeting will be held in Washington.

News Notes

ALBERTA

CALGARY: The April meeting of the Private Duty Section of the Alberta Association of Registered Nurses, the first after the convention in Edmonton, held in Calgary on April 11th, was a pleasant and successful meeting, with twenty-five members present. It was quite a representative gathering, comprising nurses from local training schools and several graduates from other schools. The report of the Private Duty Committee meeting at the recent convention was read and various phases of the nursing situation were discussed with lively interest and all hoped for better things in the future both for patient and nurse. A copy of Dr. Weir's Report was examined with much interest, and it would seem that if the private duty nurses were informed as to the wonderful work which "those higher up" have done and plan to do for the status of all nurses, it would not be difficult to make the private duty sections a valuable part of nursing organisations.

It was decided to hold regular meetings every month, except in July and August, the business to be followed by tea and a social hour. Plans for raising funds were discussed, also the practicability of using the money to inform the public as to the nursing service which is at their disposal. The meeting broke up at 10.30 p.m., with promises on all sides of faithful attendance at meetings and expressions of hope that the Section may be able to do some real work in the future.

EDMONTON: Friends of Miss A. L. Young (Royal Alexandra Hospital, 1922) are pleased to know she is progressing favourably after her operation at the University Hospital.

BRITISH COLUMBIA

GENERAL HOSPITAL, VANCOUVER: The April meeting of the Alumnae was held in the Auditorium, the president, Mrs. Ernest Gillies, in the chair. The speaker of the evening was Mrs. Stuart Jamieson, who is very well known for her interest in international affairs. Mrs. Jamieson spoke of the relations of China and Japan, and gave a good deal to think about in these times of daily newspaper reports of the constant warring. This lecture is to be followed by two others at later meetings on current events. Plans were made to entertain the graduating class next month. All are taking quite an interest and looking forward to a "Country Fair" in the Auditorium in a very short time where the old and new graduates may join hands in merry-making. Miss Doris Bullock (1922) has been appointed to the Rotary Clinic staff. Miss Rae McNabb and Miss Olive Walker have joined the staff of the City Welfare and Relief Department of the City. In a recent letter from Mrs. Charles Thomson, Shanghai, formerly Freda

Lang (1922), news was received of many of the Alumnae who are at present in the Orient. Mrs. Janet Scott and Miss Witcher who were on the staff here have arrived from Honolulu, returning there again in May. Miss Macinrot who was on the Isolation Hospital staff here is also in Shanghai. Mrs. Thomson has seen a good deal of these nursing friends and expresses relief at the more settled conditions in China. The constant booming of guns and aircraft over the International settlement was very trying to everyone, even if they felt no actual danger. Mrs. MacDonnell, formerly Maude Wooster, is also living in Shanghai and it is understood that the former Marion Fisher (1922), now married, is returning from China on furlough this fall. Both these nurses have been in China for many years. Miss Muriel McIntosh (1925) is now busy learning the Chinese language before taking up her work in the Mission Hospital at Chengtu, Szechuan, West China.

MANITOBA

GENERAL HOSPITAL, BRANDON: The Graduate Nurses' Association entertained the graduating class of the General Hospital in the dining room of that institution. Specially invited guests were: Miss C. Birtles, Miss Jean Houston and Mrs. G.R. Lyons. Mrs. E. A. Whitmore, the guest speaker gave an interesting address on "Keys of the Kingdom". The colour scheme of mauve and pink was carried out in the decorations of the room and table. Toasts were proposed to the medical profession by Miss G. Hall, and responded to by Dr. Anderson, to the Graduating Class by Mrs. Pierce and responded to by Miss Jean Myers. A pleasing feature of the evening was a musical festival of original songs rendered by various groups. The annual meeting of the association was held on this occasion when reports were made by the members of the executive, and a vote of thanks rendered to the retiring officers.

ST. BONIFACE HOSPITAL: On April 13th the Alumnae entertained the 1932 graduating class at a dinner in the spacious banquet hall of the Nurses Residence. In charge of the arrangements were: Misses Theresa O'Rourke and Clara Miller, assisted by Misses Kae McCallum, Nan Gordon, Eileen Pettit and Evangeline Edwards. The president, Miss Etta Shirley and Miss E. Parkhill received the guests. A unique feature of the evening was the presence of the first two graduates from St. Boniface Hospital, Mrs. Henriette Crossby and Miss Marion S. Suttle, they having graduated in 1899. The tables were attractively decorated with the class colours, blue and gold, and Talisman roses, daffodils and hydrangeas. During the evening a programme of music was contributed.

The Alumnae members were pleased to have the quarterly meeting of the Manitoba Association of Registered Nurses held in the assembly hall of the Nurses Residence on April 29th.

WINNIPEG: The Graduation Exercises for the School of Nursing, St. Boniface Hospital, were held on May 16th in Provencher Collegiate Institute Auditorium; those for the Winnipeg General Hospital School of Nursing took place in Grace Church on Friday, May 27th, and on the evening of May 31st, the same were held for the Children's Hospital graduating class. All were followed by receptions in the Nurses Residences.

NOVA SCOTIA

NEW GLASGOW: An association of graduate and registered nurses has been formed at New Glasgow, under the name of "The Pictou County Graduate Nurses' Association". Meetings are held on the third Friday of each month at the Nurses Home, Aberdeen Hospital. Four meetings have been held with an average good attendance. Matters of importance regarding the present situation of nurses have been discussed with keen interest, and the association shows promise of a progressive and beneficial future. Following is a list of officers: Hon. President, Miss Margaret C. Macdonald; President, Miss Daisy Gray; Vice-President, Miss May McMillan; Secretary, Miss Ethel Elliott; Treasurer, Miss Hilda Meikle; Executive Committee, Mrs. Edison Fraser, Mrs. J. W. McLeod, Misses Marion P. Boa, Nina Grant, Helene Townsend; Representatives: Private Duty Section, Miss Mabel McPhee, Miss Jessie Oliver; Public Health Section, Misses McKenzie and Robertson; Local Council of Women, Mrs. W. H. Robbins; Miss Daisy Gray, Mrs. Jos. Morris, and Mrs. R. A. Douglas; "The Canadian Nurse" Misses Jessie Robertson, Calder and Douglas; Sick Visiting Committee, Mrs. A. Enman, Miss E. C. Cowan; Refreshment Committee, Miss B. B. Kennedy.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in May, 1932, were 932, twenty more than in April, 1932.

APPOINTMENTS

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Eleanor Newberry (1925), who has had charge of the O.P.D. for five years, has resigned, and Miss Masten (1930) has been appointed in her place. Miss Isobel Hamilton (1930) is doing floor duty at the Women's Hospital, Montreal. Miss Muriel Bazin (1930) has taken charge of a ward in the Children's Memorial Hospital, Montreal.

BRANTFORD GENERAL HOSPITAL, BRANTFORD: Miss Jean Davidson (Brantford General Hospital, 1922) has accepted a position in the X-ray Department of Freeport Sanatorium, Kitchener.

DISTRICT 2

BRANTFORD: The regular monthly meeting of the Florence Nightingale Club was held on Monday evening, May 2nd. Plans were made for the June meeting, to take the form of a picnic at the Bell Homestead.

BRANTFORD GENERAL HOSPITAL: Miss Minnie Brown (1928) is a patient at Grace Hospital, Toronto. Graduation Exercises of the Brantford General Hospital School for Nurses will be held on June 3rd at the Brantford Collegiate Auditorium. National Hospital Day, May 12th, was observed at the Brantford General Hospital. Third year student nurses completed their course in Psychiatry by a visit to the Ontario Hospital, Hamilton, where Dr. J. J. Williams and his staff had prepared very interesting clinical studies. Miss Maude Campion, Miss M. Griffith, Miss E. Ruddy, Mrs. J. N. Mitchell, Miss J. M. Wilson and Miss E. M. McKee, attended the Mental Health Conference held at the Ontario Hospital, Hamilton, on May 7th. Dr. J. M. Robb and Dr. B. T. McGhie were speakers at the Conference.

WOODSTOCK: Miss M. Davison and Miss G. Jefferson represented the Graduate Nurses' Alumnae at the Provincial Convention of the R.N.A.O. held at Chateau Laurier, Ottawa. The Graduate Nurses' Alumnae, of which Mrs. A. H. Melsom is president, held a successful bridge April 8th. The Nurses Residence was made attractive with tulips and daffodils. Receiving the afternoon guests were Miss H. Potts, Miss M. Davison and Mrs. P. Johnston. Conveners of the event were: Miss E. Hastings for refreshments, Miss R. Wright and Miss A. Cook for bridge. A total of forty tables were in play during the afternoon and evening. Miss H. Potts and Miss G. Jefferson welcomed the evening players. As a result of the event a very gratifying sum was added to the funds.

DISTRICT 4

HAMILTON: A well-attended informal dinner and meeting was held at The Towers on April 22nd by the Public Health Section of District No. 4 of the R.N.A.O. for the purpose of discussing Dr. Weir's Report, with Miss Florence Emory, of Toronto, as guest speaker, and Miss Cora Taylor, councillor of the district in the chair. Miss Emory's subject was "Some Aspects of the Survey of Nursing Education in Canada as Made by Dr. Weir". She first gave an outline of the general background of the Survey and its objects, and then dealt with the three sections. The whole question of nursing education is bound up with the finances of the hospital, and under present conditions there is an annual loss to the average hospital for each student receiving satisfactory training in nursing. Dr. Weir draws an analogy between the teaching and nursing groups and suggests that the solution would seem to rest with government participation. Regarding the Private Duty Section, the speaker stated that in 1930 there was a surplus in Canada of 40%. In twenty-five cities in Canada a third

of the population has the services of approximately two-thirds of the registered nurses, but three out of eight patients of moderate means who need these services are not able to pay these nurses. Socialized nursing service would bridge the gap between the needy patient and the unemployed nurse. There should be registration of all who nurse the sick for hire. It was pointed out there is need for Community Health Service and for participation of the public health nurse. In 1930 the supply was equal to the demand. Miss Emory stated that this Survey has been valuable in gathering together facts regarding nursing and has brought together groups who can improve the situation. The hope was expressed that in a few years nurses might look forward to a second survey showing marked progress along the line embodied in the recommendations of this report. Miss Rayside expressed her appreciation to the Public Health Section for bringing Miss Emory to Hamilton, and made it known that copies of the Survey Report were available at the Hospital, and impressed upon all present the necessity of reading the Report.

DISTRICT 5

COLLINGWOOD: A meeting of the Alumnae, Collingwood General and Marine Hospital, was held in the hospital on April 25th. The Honorary President, Mrs. Price and the President, Miss R. Hanley, and nine members were present. The secretary's and treasurer's reports were read and approved. Several discussions followed regarding a medal for graduation, linen for the nurse's room and the purchasing of the Alumnae pin. It was decided to hold a Progressive Euchre at the Nurses Residence on May 13th. Miss S. Johnston, the assistant superintendent, was asked to prepare a paper for the next meeting, choosing her own subject.

GENERAL HOSPITAL, OSHAWA: The annual At Home of the Alumnae Association was held at the Genosha Hotel, on April 7th. Over one hundred couples were present making the evening very successful. Miss Amber Souley and Miss Helen Hutchison were delegates to the Registered Nurses of Ontario Convention held at Ottawa.

TORONTO: A general meeting of the Community Health Association of Greater Toronto was held in Osler Hall, Academy of Medicine, on April 22nd, when one hundred and seventy nurses interested in community problems attended. Reports were read from the Study Committees on Maternal Welfare and the Pre-school Child. Mrs. Harriet Mitchell, Director of Parent Education, Mental Hygiene Institute, Montreal, was the speaker of the evening. Her subject was Mental and Physical Aspects of the Pre-school Child. She outlined briefly the education of the child from the early days of civilisation and spoke at greater length upon the value of modern ideas of parent education and child guidance.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Una Ross (1929), is holidaying in Pratt,

Kansas. Miss Grindley, Hospital for Sick Children, was a delegate to the R.N.A.O. Convention at Ottawa.

WESTERN HOSPITAL, TORONTO: The regular meeting of the Alumnae was held on April 12, 1932. An interesting item of the programme was the welcoming of the graduating class as members of the Association. An excellent report of the R.N.A.O. Convention in Ottawa was given by Miss Beamish, the president. The guest speaker of the evening was Miss Mary Millman, President of the R.N.A.O., who outlined some of the aims of that organisation and pointed out the benefits obtained by membership in the Registered Nurses Association. Tea was served and a social half hour closed the meeting.

DISTRICT 6

Chapter 3 of District 6, R.N.A.O. held their meeting at Nicholl's Hospital, Peterborough, March 29th, at 7.30 p.m. with Miss Dixon presiding. There was a splendid attendance at this meeting. Several members of the Chapter expressed their opinion that the members should have some worthy object to work for, locally. There was keen discussion over this, finally it was approved that for the present the Chapter work towards a Nursing Benefit Fund, for the members; also, the members decided that a picture be sponsored and that Miss Simmons, with her committee, arrange for the same. Miss Matchett kindly offered her home for three tables of bridge, followed by a Waffle Supper.

DISTRICT 8

CIVIC HOSPITAL, OTTAWA: The Alumnae Association held a tea in the Nurses Residence on May 1, 1932. The guests were received by Miss Gertrude Bennett, Miss E. Maxwell and Miss Evelyn Pepper. Over one hundred members were present. Mrs. Eldon Veitch and Mrs. V. Craig presided at the tea table, and the ices were served by Mrs. Wilfred Parmalee. The following assisted: Misses Grace Froats, Gertrude Maloney, Margaret MacCallum, Winnifred Gemmell, Dorothy Moxley, Beth Graydon, Gertrude Ferguson, Mary Luton, Greta Wilson, Emily Fallas, Margaret Normand and Katie Clark.

QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss E. C. Flanagan (1923), and Miss Riches (1932), are leaving shortly to take post graduate courses in London and Edinburgh. Miss Betty Bartlet (1930) is doing public health work in Windsor, Ont. Miss Dorothy Gordon (1931) is taking a post graduate course at Ste. Agathe Sanatorium. Miss Katherine MacLennan (1930) has accepted the position of Instructor at the Alexandra Hospital, Montreal. Miss Helene Wilson (1931) is doing floor duty at the Shriners' Hospital, Montreal.

SASKATCHEWAN

MOOSE JAW: The Annual Graduation Exercises of the Moose Jaw General Hospital were held in Zion Church on May 3rd. Sixteen nurses received their medals and diplomas.

C.A.C.N.S.

TORONTO: Toronto Unit, Overseas Nursing Sisters Association of Canada, held a very jolly bridge party in the Sisters Quarters at Christie St. Hospital on Friday, May 6th. These reunions of the Club are always most enjoyable as well as remunerative, and the Treasurer reported proceeds of \$76.00 from 36 tables at 50 cents a player. Expenses were negligible as the refreshments were provided by members as usual. Mrs. Jack Bell, the president, and members of the executive missed very much the assistance of the genial hostess Matron Hartley, A.R.R.C., who is at present ill in hospital. Miss McCallum represented Miss Hartley and was assisted by Miss Drysdale.

WINDSOR: Miss Agnes Gordon, Miss Myrtle Fielder and Mrs. Watson were hostesses to the Overseas Nursing Club at their regular meeting held on March 17, 1932, at the Receiving Hospital, Detroit. A large number were present, and at the close of the business meeting the members were shown through the Psychopathic Wards and other interesting departments. Refreshments were served before returning to Windsor by way of the tunnel. Miss Emily McLaughlin, Essex County Sanitarium was hostess to the Club for their regular meeting on April 15, 1932. The members were entertained at bridge followed by supper. The May meeting was to be held at the home of Mrs. (Dr.) Brown, Walkerville.

Correction—On page 266 of the May number of the journal, in the News Notes from the Children's Memorial Hospital, Montreal, the name Miss Frances Eaton, Registrar, Montreal Graduate Nurses' Association should have read Miss Frances Upton, Registrar, Association of Registered Nurses of the Province of Quebec.

VICTORIAN ORDER OF NURSES FOR CANADA

Miss Elizabeth Smellie, Chief Superintendent, was a speaker at the Mother's Day Festival, arranged by the Child Welfare Council of Toronto held at the King Edward Hotel on May 9th.

The annual meeting of the Order was held at the Chateau Laurier, Ottawa, on May 11th and 12th.

At meetings of the Ontario Medical Association held at Milton, St. Thomas and Goderich during April and May, a demonstration of the work of the Order throughout Canada was given by Miss Muriel Winter, Toronto Branch.

TORONTO BRANCH: During Eaton's Baby Week, demonstrations of the care of the baby were given morning and afternoon in the Infant Welfare Department at the store, by groups arranged through the Child Welfare Council. Miss Vera Allen, Miss Grace Milne and Miss Loughheed gave the demonstration on afternoons during the week. Miss Jean Derby, who is on extended sick leave and has been at her home in Durham, Ont., is now a patient in St. Johns Hospital. Miss Louisa Reid who has been ill the past few weeks is now at Preston Springs. At the annual meeting of the Staff Council held on May 4th Miss Eva Bayne was re-elected President, Miss Winter and Miss Rogers Vice-Presidents, Miss Loughheed Secretary, and Miss Stevenson, Treasurer.

BIRTHS, MARRIAGES AND DEATHS**BIRTHS**

BANNERMAN — Recently, at Hanover, N.H., to Mr. and Mrs. H. W. Bannerman (Harriet MacIntosh, Hospital for Sick Children, Toronto, 1927), a daughter.

BLAIR—On March 2, 1932, at Edmonton, Alta., to Mr. and Mrs. T. Blair (Edythe McTavish, Medicine Hat Hospital, 1929), a daughter, Jessie Margaret.

CHRISTENSEN—On February 24, 1932, at Edmonton, Alta., to Mr. and Mrs. C. P. Christensen (Edna Stevenson, Royal Alexandra Hospital, 1920), a daughter, Vera Mae.

HEFFERING—Recently, at White Plains, N.Y., to Dr. and Mrs. R. Heffering (Louise Downs, Hospital for Sick Children, Toronto, 1926), a son.

KERR—Recently, at Toronto, to Dr. and Mrs. W. J. Kerr (Mabel Martin, Hospital for Sick Children, Toronto, 1924), a son.

KNOWLES—On April 8, 1932, at Ottawa, to Mr. and Mrs. George Knowles (Gladys Winters, Ottawa Civic Hospital, 1929), a daughter.

McADAM—On April 21, 1932, at Ottawa, to Mr. and Mrs. J. M. McAdam (Laura Wright, St. Luke's General Hospital, Ottawa), a daughter.

SUTHERLAND—On February 4, 1932, at Woodstock, Ont., to Mr. and Mrs. Burns Sutherland (Anne Schofield, Woodstock General Hospital, 1925), a daughter, Margaret Jean.

TILSON—On March 10, 1932, to Mr. and Mrs. Carman E. Tilson (F. Enid Stevenson, Hamilton General Hospital, 1926), a son.

WILLIAMS—On April 6, 1932, at Toronto, to Mr. and Mrs. Russell H. Williams (Elsie M. Sleeman, Grace Hospital, Toronto, 1922), a son.

MARRIAGES

BANNERMAN — MUMBERSON — On April 16, 1932, at New Towell, Betty Mumberson (Collingwood General and Marine Hospital, 1931), to Horace Bannerman, of Stayner.

BROWN — MACINTOSH — On February 9, 1932, at Toronto, Ont., Jean MacIntosh (Hospital for Sick Children, Toronto, 1927) to Donald Brown.

BURKHARDT — ROBERTS — On March 15, 1932, at Indianapolis, U.S.A., Evelyn Roberts (St. John's Hospital, Toronto, 1930) to Dr. Boyd A. Burkhardt, of Clifton, Indiana.

COOMBS — PIERSON — Recently, at Toronto, Eva Pierson (St. John's Hospital, Toronto, 1925) to A. Coombs, of Toronto.

CUNNINGHAM — MCHUGH — On March 28, 1932, at Woodslee, Ont., Margaret McHugh (Hotel Dieu Hospital, Windsor, Ont., 1927) to Harold Cunningham, of Detroit, Michigan.

FRASER — OVEREND — On April 20, 1932, Effie M. Overend (Winnipeg General Hospital, 1917) to Donald D. Fraser. At home, Quesnel, B.C.

GILROY — JOHNSTON — On March, 23 1932, at Kemptville, Ont., Hilda Johnston (Oshawa General Hospital, 1921), to Chester Gilroy.

GREEN — BIGGAR — Recently, Alice Biggar (St. John's Hospital, Toronto, 1930) to Harold Green, of Blind River, Ont.

HOGARTH — SHERMAN — On March 30, 1932, at Owen Sound, Ont., Mary E. Sherman (Owen Sound General and Marine Hospital, 1929) to Gordon Hogarth.

KEITH — ELEANOR — On April 4, 1932, at London, England, Grace Eleanor (Hospital for Sick Children, Toronto, 1925) to Dr. William Keith.

LYONS — MCKEE — On April 9, 1932, Elva Anna Mae McKee (Lamont Public Hospital, Lamont, Alta., 1925) to William George Lyons, of Toronto.

MACRAE — BURGESS — On March 19, 1932, at Toronto, Ont., Frances Jean Campbell Burgess (Grace Hospital, Toronto, 1930) to Farquhar John MacRae, of Toronto.

THOMPSON — BURRELL — On April 16, 1932, at Caledon East, Ont., Helen Burrell (Grace Hospital, Toronto, 1931) to William Thornley Thompson, Toronto.

THURSTON — CORNISH — On February 6, 1932, at Kendal, Ont., Lenora P. Cornish (Oshawa General Hospital, 1931) to Wallace D. Thurston, of Bobcaygeon, Ont.

WOODS — MYERS — On April 30, 1932, at Westport, Ont., Vera M. Myers (Ottawa Civic Hospital, 1926) to Duncan Woods, Phm.B., of Ottawa.

DEATHS

AUGER — On May 2, 1932, at Medicine Hat, Edna Mabel Auger, R.R.C., Medicine Hat General Hospital, 1906.

INTERNATIONAL HOSPITAL ASSOCIATION

A Post Graduate Course on Hospital Technique is being arranged by the International Hospital Association, with headquarters at the Municipal and University Hospital, Frankfurt. The date is September 29th to October 8, 1932.

Applications for enrolment should be sent before July 1, 1932, to Geheimrat Dr. Alter, 5 Moorenstraße, Dusseldorf, Germany.

The programme includes discussion of hospital administration in its various phases. Miss C. Reimann, Secretary, International Council of Nurses, will discuss The Recruiting of Nursing Staff, and Examinations to Determine its Aptitude. The course will consist of lectures lasting not more than forty-five minutes, demonstrations, visits and discussions.

Contributors to the News Notes Section are requested to keep in mind that the closing date on which contributions can be received at 511 Boyd Building, Winnipeg, Manitoba, and be assured publication in ensuing issue is the twelfth of each month.—Editor.

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REGISTERED NURSES' ASSOCIATION OF ONTARIO (Incorporated 1925)

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Regular meeting first Tuesday in month.

A.A., LAMONT PUBLIC HOSPITAL, LAMONT, ALTA.

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A.A., ROYAL ALEXANDRA HOSPITAL, EDMONTON, ALTA.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

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Hon. President, Mrs. W. A. Moody, 97 Ash St.; President, Mrs. J. A. Davidson, 39 Westgate; First Vice-President, Mrs. S. Harry, Winnipeg General Hospital; Second Vice-President, Miss I. McDiarmid, 363 Langside St.; Third Vice-President, Miss E. Gordon, Research Lab., Medical College; Recording Secretary, Miss C. Briggs, 70 Kingsway; Corresponding Secretary, Miss M. Duncan, Winnipeg General Hospital; Treasurer, Mrs. H. I. Graham, 99 Euclid St.; Sick Visiting, Miss W. Stevenson, 535 Camden Place; Programme, Miss C. Lethbridge, 877 Grosvenor Ave., Membership, Miss A. Pearson, Winnipeg General Hospital.

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Meetings held first Thursday every month.

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

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A.A., KINGSTON GENERAL HOSPITAL

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HOSPITAL**

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A.A., NIAGARA FALLS GENERAL HOSPITAL

Hon. President, Miss M. S. Park; President, Mrs. J. Taylor; Vice-President, Miss L. McConnell; Secretary, Miss J. McClure; Treasurer, Miss I. Hammond, 632 Ryerson Crescent, Niagara Falls; Convener Sick Committee, Miss A. Irving; Asst. Convener Sick Committee, Miss Coutts; Convener Private Duty Committee, Miss K. Prest.

A.A., ORILLIA SOLDIER'S MEMORIAL HOSPITAL

Hon. President, Miss E. Johnston; President, Miss G. Went; First Vice-President, Miss McMurray; Second Vice-President, Miss S. Dudenhofer, Secretary-Treasurer, Miss M. B. MacLelland, 128 Nississaga St. W.

Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

Hon. President, Miss E. MacWilliams; President, Mrs. Mabel Yelland, 14 Victoria Apartments, Simcoe St. South, Oshawa; Vice-President, Miss Jessie McIntosh; Secretary, Miss Helen Batty, Brooklin, Ont.; Treasurer, Miss Jane Cole; Corresponding Secretary, Miss Helen Hutchison, 14 Victoria Apartments, Simcoe St. South, Oshawa.

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A.A., LADY STANLEY INSTITUTE, OTTAWA (Incorporated 1918)

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A.A., OTTAWA CIVIC HOSPITAL

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A.A., OTTAWA GENERAL HOSPITAL

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A.A., OWEN SOUND GENERAL AND MARINE HOSPITAL

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A.A., NICHOLLS HOSPITAL, PETERBORO, ONT.

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A.A., SARNIA GENERAL HOSPITAL

Hon. President, Miss M. Lee; President, Miss L. Seigrist; Vice-President, Miss B. McFarlan; Secretary, Miss A. Silverthorne; Treasurer, Miss M. Woods; "The Canadian Nurse," Miss E. Dickey; Flower Committee (Convener), Miss J. McKenzie; Programme and Social Committee, Misses P. Humphrey, O. Banting, B. McFarlan; By-laws Committee, Misses O. Banting, M. McCrae, E. Dickey.

A.A., STRATFORD GENERAL HOSPITAL

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A.A., MEMORIAL HOSPITAL, ST. THOMAS, ONT.

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The Injection Treatment of Varicose Veins

By J. H. COUCH, M.B., F.R.C.S. Edin., Department of Surgery, Toronto General Hospital

The treatment of varicose veins has been revolutionised during recent years. Only a short time ago the regular treatment was by operation. A tedious dissection was involved, and long, unsightly scars remained at the various points of incision between the upper thigh and ankle. Nor were the final results satisfactory. Aside from expense and tedium of a convalescence lasting from four to six weeks, the enlarged veins themselves recurred in 15% of cases, and approximately $\frac{1}{2}$ of 1% of all patients subjected to operation died of an embolus to the lung.

Varicose veins may now be completely cured without interfering with the patient's daily routine of work. The operation involves nothing more than a needle prick, no scars are left, about 4% only recur, and the number who die from pulmonary emboli is only 1/70 as great as under the former treatment. In fact, the danger of emboli is probably less in cases treated by injection than if left untreated.

History: The history of the modern method may be briefly sketched. In the latter half of the last century physicians in Germany and France observed that the intravenous administration of strong chemicals in the treatment of syphilis sometimes caused thrombosis of veins. This led them to attempt deliberately to thrombose varicose veins. The results were excellent as far as thrombosis was concerned, but the chemical re-

actions were so severe that sloughs and ulcers occurred. For this reason the injection treatment fell into disrepute. It has been revived with the discovery of more suitable chemicals and it is now possible to produce an excellent thrombosis of the veins without the unhappy consequences which were previously so common.

The incidence of varicose veins seems to be increasing in civilised communities, although it is difficult to arrive at any accurate estimate of the number of people suffering from this disease. If one may judge from the numbers who seek relief when opportunity is presented, it is safe to say that there are many who have suffered for a long time without complaint. Their disability, while exhausting, is not quite severe enough to justify extensive operation.

Complaints: The reasons which bring the patient to the doctor vary. With some, particularly young people, it is pride. They dislike this disfigurement, of which they are constantly conscious, and which interferes definitely with their happiness and ability to enjoy life. When in public they remain constantly in the background, fearful lest others remark their veins. Fear brings others, who have seen people with enormous varicose veins, and who, with good reason, fear that their own may become worse. The fear that the vein may burst and bleed dangerously is also an ever-present reality. Patients have been brought into hospital so

exsanguinated as to be pulseless and unconscious. Chronic ulcer is the terror of some patients. A large, repulsive and painful sore from which there seems no escape for years is an affliction which has limited the success of more than one. Some patients seek relief because of pain and aching aggravated by standing, while a few complain that their feet and ankles swell.

Circulation: An understanding of the venous circulation in the leg is necessary if the treatment is to be understood. The muscles of the leg are ensheathed in a strong, unyielding covering of deep fascia, within which are large veins, well supported by muscles, capable of enormous work, and rarely subject to varicosities. It is these veins which are damaged in "milk leg," or any form of deep thrombophlebitis. Under normal conditions the work of these deep veins consists of the return of blood from the muscles and bones. On the outside of the deep fascia is another set of veins lying in the fat and superficial fascia under the skin. These veins are not supported by muscle and are prone to become dilated and varicose when unfavourable conditions arise. Their function is normally to return the blood from the skin and superficial fascia to the deep veins in the groin.

Causes: Varicose veins are not produced by any single cause, but in all cases several factors are at work. Predisposing factors are heredity and debility following illness. Over 50% of patients give a positive family history, while the incidence of varicose veins in the general population is distinctly less than 50%. Microscopic investigation reveals veins which are actually thin walled and weak. If an individual who inherited poor veins be debilitated by illness and then subjected to circumstances which harass the return of blood from the leg, varicosities of the superficial veins may occur. Occupation is frequently a precipitating factor, as is illustrated

by the suffering of nurses, teachers, salesgirls, housewives, storekeepers, and policemen. Intra-pelvic pressure, most commonly due to pregnancy, may be a further precipitating cause. This slight interference with the ready return of blood prolonged over a period of nine months may cause varicosities or aggravate an already existing condition.

Once a slight dilatation has occurred, the valve cusps no longer meet in the centre of the vein and blood leaks back past them. Normally, there are no valves in the intra-abdominal or thoracic veins. Therefore, in such cases, the superficial, unsupported veins are forced to bear the weight of a column of blood extending from the foot to the heart, which represents in the erect position a considerable lift against gravity. It has been demonstrated that the pressure in certain parts of varicose veins may reach 170 millimetres of mercury, or 40 millimetres greater than arterial blood pressure. Since these veins are denied the most powerful emptying force, namely, massage by muscle action, it is to be expected that they should sometimes fail. Gravity overcomes the propulsive force, the flow is reversed, the vein below dilates and stretches, and a typical tortuous varicose vein results. As the blood flows slowly down, it perfuses the skin and superficial fascia with useless, stagnant blood low in oxygen and food content, dams back the inflow of fresh blood from the arterial capillaries, and finally finds its way by means of communicating branches through the deep fascia into the capable and tolerant, but not inexhaustible deep veins, by which it is then carried upward toward the heart. At the saphenous opening in the groin some overflows back down into the long saphenous vein, and a vicious circle is established. Thus it becomes evident that veins which have become varicose not only fail to perform any useful function, but they are worse than useless because they compel the deep veins to

do not only their own work and the work of the superficial veins, but even to do some of this work over and over again. It is for this reason that the obliteration of the superficial veins actually improves the circulation in the leg.

Contra-Indications: It might be well here to mention the more important contra-indications to the injection of veins. In some cases of "milk leg" or deep thrombophlebitis, often associated with pregnancy, typhoid fever or following operation, this excellent system of deep veins has been permanently damaged and the superficial veins are compelled to carry most of the blood from the whole leg. While they do this work poorly enough, they still represent almost the only return circulation that the patient has and they must never be injected. In patients with thrombosed deep veins, the superficial veins become large and tortuous from overloading, but their flow is upward in the correct direction. Acute or subsiding phlebitis is a second definite contra-indication to injection, and is evidenced by heat, redness, swelling, pain, and tenderness along the vein. The further irritation in the presence of acute inflammation may result in a widespread extension of the process, which assumes dangerous proportions. An acute inflammatory process anywhere in the body should be cured before veins are treated. Boils or acute sore throats are sometimes accompanied by bacteria circulating in the blood stream, which would find a favourable site for growth in a recently clotted vein. The exact cause of the patient's symptoms must be determined. It is obvious that injection of varicose veins will not relieve the swelling of chronic nephritis or of heart disease, nor will it ease the pain of arthritis or fallen arches; yet all of these are encountered in the clinic.

Technique: The technique of injection treatment is simple in itself, but attention to the details mentioned is necessary if good results are to be

obtained and if distressing complications are to be avoided. The patient is seated on a table with the foot resting on a bench below, while the operator sits in front. A small glass syringe, with a long, fine-bore needle (24 gauge, long hypodermic needle) and having a short bevel and a sharp point, is introduced, bevel down, into the vein. When blood is seen in the tip of the syringe the vein is stripped empty above and below by means of the thumb and first finger of the left hand and the contents of the syringe is injected rather quickly. One cubic centimetre of 5% sodium morrhuate is injected in each of two places at each sitting. The two places are usually about four inches apart and cut off a segment of the same vein. Immediately on withdrawing the needle the vein is compressed at the site of puncture by means of a small pledget of cotton held firmly in position with a strip of adhesive for forty-eight hours. The patients are encouraged to continue their ordinary duties. Such injections may be repeated in other affected veins once or twice weekly, and about five sittings are required for the average case.

Rationale: The aim of the treatment is not, as is sometimes thought, to produce a clotting of the blood within the vein. The primary object is to produce a severe chemical damage to the intimal lining of an empty vein in order that a sterile inflammatory reaction may be caused and the two walls of the vein fused together. As a secondary effect it naturally follows that any blood left within the vein must undergo clotting, but the clot is sterile, as against that formed in ordinary thrombophlebitis of infectious origin. The injection of the irritant chemical causes the vein to go into spasm which contracts it to small size, the intimal lining is damaged, the two walls are fused together, and the sterile thrombus which does result is in a contracted, damaged vein, and is therefore small and ad-

heres firmly to the vein wall. These are, perhaps, the main reasons why emboli from veins so treated are so rare. In addition, the fact that the reverse flow of blood tends to jam the clot tighter into the vein rather than to wash it into the general circulation may be of some value in preventing emboli.

Normal Course: As a result of the injection treatment the affected veins normally become small and hard at once, and this reaction may extend in either direction from the point of injection for a distance of about four inches. Sometimes a slight brownish discolouration appears over the hard vein, and occasionally the sterile inflammatory reaction extends out for one inch on either side of the involved vein. This results in a feeling of stiffness and soreness and the production of a tender, hard mass which may cause some discomfort for forty-eight hours, but which need not interfere with the patient's work. Any tenderness or redness should disappear within a day or so, leaving the small, hard, lumpy veins, which are absorbed and disappear of themselves in about six months.

Untoward Effects: Occasionally untoward effects follow such treatment, due either to individual idiosyncrasy or to errors in technique. (1) Cramps in the muscles, usually of the calf, may be encountered. This condition seems to vary with the chemical used for injection. Strong saline solutions are particularly likely to produce them, but they usually disappear in two minutes and the results thereafter continue to be normal. (2) Local pain may occur at the site of injection. This is a severe stinging pain and it indicates that some of the solution has been injected outside the vein wall. The injection should be discontinued immediately. (3) Toxic manifestations may follow the administration of various drugs in individuals who happen to carry a sensitivity to this particular substance. Thus, severe headache, buzzing in the

ears, and even uterine contractions have been produced by small doses of quinine, while in others a distressing and widespread, though transient, urticaria occurs. This may be satisfactorily controlled by the hypodermic administration of 10 minims of adrenalin.

Further, such unhappy consequences as the following may occur some time after the injection treatment: (1) *Periphlebitis*; the normal inflammatory reaction involves the surrounding tissue to an undue degree. Patients so affected suffer from widespread, hard, red, tender swelling following the course of the vein. They should be put to bed and cold saturated magnesium sulphate compresses should be applied until the condition subsides, usually within five or six days. (2) *Slough*; if the strong irritant chemical solution is injected outside the vein and immediately under the skin it destroys an overlying area of skin, about one inch in diameter. This area sloughs, leaving an indolent ulcer. Such an area of slough, having occurred, is relieved most quickly by excising completely the involved area and suturing the edges in the hope of primary union. (3) A small subcutaneous hæmorrhage may occur at the site of injection after the needle is withdrawn. This results in a black and blue spot and is due to the fact that the vein walls in such an individual are particularly fragile, so that they tear readily and permit hæmorrhage into the surrounding loose tissue. (4) *Emboli* are reported. A piece of the clot breaks off, is carried to the right heart, from there through the pulmonary circulation to the lung, where it lodges, resulting in pulmonary embolism, a dangerous complication, which is, fortunately, very rare and which has been discussed above.

Ulcers: Varicose veins untreated do not improve, but rather become slowly and steadily worse, and are likely to be followed by disabled sequelæ, the worst of which are re-

peated cellulitis and ulceration. It may be well to discuss briefly at this point the nature of these ulcers. The presence of varicose veins results in an impoverished blood supply to the skin of the leg, so that slight injury precipitates ulceration, which is slow to heal. Infection readily lodges in the devitalized tissues and the ulcer is soon surrounded by a zone of cellulitis, which constitutes a real source of danger as well as causing considerable pain and suffering, and which is followed by further fibrosis and further difficulty in healing. There are, then, many factors which contribute to the chronicity of such ulcers, and attention must be directed toward the correction of all contributory factors if intractable ulcers are to be healed and kept healed. The cure of ulcer necessitates several stages, which must be faithfully followed through if the desired goal is to be attained. While the injection of remaining varicose veins is essential, the injection of veins alone will not often result in cure. The ulcers are dressed with antiseptic dressings until clean. Eusol or hygeon, diluted and applied cold twice daily, have proven efficacious. The use of ointments is to be condemned, because they result in maceration of tissue, spread of infection, and the establishment of further chronicity. When the ulcer is clean a circular Unna's paste stocking is applied from the base of the toes to the tuberosity of the tibia. This is put on first thing in the morning when oedema is at a minimum, and is

left on for five weeks. The secretion from the ulcer, which collects under the paste, is of actual curative value to the ulcer. It is usually necessary to renew the cast once or twice at intervals of five weeks before healing is complete.

Operations: Operative surgery has a place in the curing of some ulcers, particularly those complicated by fibrosis, scarring, lymph-oedema, or arteriosclerosis, which are not healed by the procedures outlined above. Skin grafting will cover quickly a large granulating surface and so avoid loss of time and further fibrosis. Division of the saphenous nerve will relieve the pain of irritable ulcers lying within the saphenous nerve distribution, thereby permitting adequate dressings, and will also improve the blood supply to some degree. Lumbar sympathectomy will improve the blood supply of the whole leg, and in selected cases will relieve pain, diminish oedema, and improve blood flow, thereby facilitating healing or improving the bed so that full thickness flap grafts may survive.

Conclusions: It has been the purpose of this article to draw attention to a prompt and efficient treatment which has recently been made available for an affliction that has long presented a tedious and unsatisfactory problem to doctors, as well as distressing the sufferer physically, economically and psychologically; and to indicate that further progress in the handling of this disease and its complications is still to be expected.

*Marketing Mass Education**

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Many discussions pertaining to health education lead early in their course to confusion of thought because the phase of the subject discussed is not made clear at the outset. To avoid this difficulty the Public Health Education Section of the American Public Health Association several years ago, proposed a terminology for common use. Phraseology was then recommended to define three types of public health educational activity:

1. The formal academic instruction given to students of health was designated as "public health training." (Two different types of training are actually embraced under the terminology "public health training." On the one hand it includes the curricular courses designed for those who are studying to equip themselves as public health workers of one type or another, i.e., public health nurses, engineers, epidemiologists, etc.; and on the other hand, it includes the incidental training in hygiene or public health given to those who may later become auxiliary aids in the public health campaign, for example, teachers, social workers, and physicians.)

2. The training of children in the school and elsewhere in health habits and the principles of hygiene and public health was designated as "child health education," and this term has become well established.

3. The less formal activities directed to the education of the adult population were designated "popular health instruction," phraseology which has not been widely accepted.

The implication here that you cannot educate the mass but only instruct it suggests defeat at the outset.

The subject of this paper cuts somewhat across all three of these distinctive lines of endeavour. In the main, however, it concerns adult health education and child health education outside the classroom. Because neither of the fields indicated, singly or together, serve to emphasize the extent of the problem here in mind (its scope and the methods it necessitates being far beyond those commonly visualised) we have borrowed from contemporary popular educators in China the term "mass education."

By "mass education in health," is meant the dissemination among the whole population of knowledge gained by the technical worker in the field and laboratory to the end that this knowledge may be applied individually and collectively for the prevention of disease, the postponement of death, and the building up of a vigorously healthy population.

Failure to discriminate between the terms "hygiene" and "public health" also results in confusion at times. The one concerns the individual and his personal acts. The other concerns the individual only as a unit of society and his part in the collective acts of the group. Mass health education is concerned with both hygiene and public health and needs to distinguish between them in formulating its programmes.

It is not necessary perhaps here to dwell on the importance of public health education. But there have been times in these counsels when the importance of adult education has been allowed to become obscured by

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emphasis on child health education. Adult education has been considered, when at all, chiefly as instruction in personal hygiene temporarily necessary to correct earlier deficiencies in child health education. Some would have us believe that if we could only thoroughly train one generation of children the necessity for adult health education would thereupon cease. The child is father to the man but the man is also father to the child. And this relationship has significant implications for health educators. In a diphtheria immunisation campaign or in such instances as the recent epidemic of infantile paralysis, prevention depends on adult understanding. In many instances, adult education provides society with its only opportunity for reaching the child.

Our whole programme of child education is dependent upon a certain amount of adult education, at the very least an amount sufficient to approve appropriations for teachers' salaries. Much educational effort with children is nullified by adult example. Indeed it is often nullified by the example of the teacher herself. It is doubtful if such nullification would be eliminated by offering adequate health education in their youth to future adults, parents and teachers.

How much of the content of one's early training is really carried into adult life? If the principles of health taught in childhood are to maintain their brilliant reality through all the amazing experiences and expanded horizons of adult life, the education of the individual must be everlastingly kept at, through grade school, high school, college, and mature adult life. What Bruce Barton says of advertising is equally true here: "You can't advertise today and quit tomorrow. You are not talking to a mass meeting—you're talking to a parade."

Even though we accept the importance of continuous mass educa-

tion we have but rude implements with which to perform our tasks. We pour our time and money into posters, pamphlets, lectures, motion pictures and the radio, but we do not know very much about the relative educational value of these techniques. Who can say in what circumstances a radio talk is more effective and economical than a motion picture or when a poster will get better results than a pamphlet? Our measurement of the effectiveness of printed matter has too often been in terms of good printing, not in terms of life saving. This is as if the serologist strove for a serum which was crystal clear rather than for one which produced immunity. We cannot assume that because good printing pleases us it will please the public, or that if pleasing it will result in action. It may be that poor printing would save more lives than good printing.

Who can prove that his established use of any cherished medium has value in terms of life saving? What have we to show that the general health of a group exposed to prolonged health educational ministrations is any better off therefore? In our scant attempts to prove the value of our techniques, we have been content with subjective standards.

Largely because they have proceeded empirically, health educators are tolerated as step-children in the family of public health scientists. The laboratory man and the health officer have shown that toxin-antitoxin prevents diphtheria. The engineer has reliable statistical evidence that protection of a water supply decreases the incidence of typhoid fever. The public health nurse, the statistician, and the epidemiologist can produce convincing proof of the life saving value of their efforts. If mass education in health is to assume its legitimate place as a valuable routine in the public health campaign, equal in rank to vital statistics, bacteriology, or administration, the value of its methods must be proved, and newer

and more effective methods found. It may be no more difficult to establish scientifically the value of our educational techniques than it was to establish the value of present-day routines of communicable disease control. Those routines now appear to have been so easily proved, only because they have been proved.

The stern discipline of the laboratory and the brilliance of its results have attracted millions of dollars for research. As a result we have, compared with the past, a tremendous store of knowledge in preventive medicine. This is a store in the warehouse sense in that for the most part this knowledge is stored away in textbooks and journals, hidden from the layman among incomprehensible words and symbols and disguised with appalling statistics. Yet the research worker has performed his task. He has found the knowledge he sought. We have failed to make this knowledge available for the service of mankind. Production of knowledge has far outstripped consumption.

It is frequently argued that mass education in health cannot be effected because the public is not interested in health. This argument is fallacious. It is an alibi undoubtedly often used when salesmen first tried to introduce the "horseless carriage." But the science of public health is not in the "horseless carriage" stage. There is abundant evidence of a ready market for health. Last March we visited the boardwalk at Coney Island. In spite of bristling weather, we found crowds gathered to listen to so-called health lectures by modern medicine men. These spellbinders are known as pitchmen. They sell books, rubber exercisers, psylla seeds, ointments, tonics and whatnot. They appreciate the dollar and cents value of the health appeal and the visual method. They constitute a clearly defined group on the edge of the entertainment profession. The health appeal has been seized upon

also by producers and distributors of all types of articles in selling their wares. Automobiles, soap, refrigerators, underwear, toys, books and, of course, all sorts of foods are urged upon us for their health value. That the health motif has such universal commercial importance would indicate sufficient popular interest to insure success in any mass movement in health education, if the proper techniques were used.

Hope for the future lies in our emergence from the empirical stage. With the help of our scientific confreres, we must test by objective standards our long established practices. But while undergoing such self-analysis, and perchance resultant housecleaning, we cannot profitably sit idly watching the parade go by. The problem of mass health education here outlined calls for the inauguration of methods adequate to the new concept which has already been caught by commercial interests.

That mass education, conceived in the broadest possible terms, is necessary to secure the utilisation by individuals and communities of available demonstrated health knowledge, which, applied, would lengthen life and make it happier, this group does not need to be persuaded. Any methods, new or old, which will help to raise the health intelligence of the masses, this group will welcome. Proponents of visual methods of health instruction believe that wider use in America of the museum method, its value in other fields long since well established, will be a means of reaching thousands of individuals who are now indifferent to other appeals.

The museum of hygiene has demonstrated its success in Germany and elsewhere. As a museum it is not merely a repository of historical objects and data but a true educational institution. It is fundamentally a permanent exhibition of devices cleverly arranged to command interest and crystallise understanding.

Such an institution would draw its elements from many sources. It would be equipped with workshops, research laboratories, lecture rooms, a library, broadcasting studio and auditorium, in addition to spacious exhibition halls. It would serve as a centre for research, experimentation and demonstration in visual and other unexplored methods for disseminating health knowledge.

There is probably no better existing model for such an institution than the Deutsches Hygiene Museum in Dresden. A museum like that in Dresden, adapted to American needs and medical standards, would be an important adjunct in spreading health knowledge among the masses, as well as in offering health education in elementary and secondary schools. It would also be a valuable aid in teaching hygiene in schools of medicine. For industry, as well, such visual instruction as only a museum could provide would be of inestimable benefit in instructing workers in accident prevention and health preservation.

A suitable building for such a museum would have ample proportions, easy accessibility, and possibilities for future enlargement. Among the exhibits would be wax, glass and plaster models, charts, and posters. They would visualise all health problems related to the more common diseases in a manner so graphic and dramatic as to command the attention of the average layman and be readily understood by him. They would provide instruction on the structure and functions of the various parts of the body. They would illustrate such subjects as biology, personal hygiene, mental hygiene, care of the teeth, nutrition, prenatal, postnatal, and child care, communicable disease control, tuberculosis, venereal diseases, tropical diseases, hygiene of work and the protection of the worker.

The Deutsches Hygiene Museum began its existence in 1911 in con-

nection with the first International Hygiene Exhibition. In 1930,^① the opening of a new and spacious permanent building for the Museum served as an occasion for holding in Dresden the second International Hygiene Exhibition, an event which was repeated in the summer of 1931. The permanent exhibits which this new building houses are the last word in visual health instruction. The charts, specimens, models and apparatus used are striking in design and compelling in interest.

A unique feature of many of the displays is their movability, that is, many models are so arranged that the museum visitor may operate them by turning a crank, pushing a lever or touching a button. This not only excites curiosity but compels attention and probably assures that the lesson of these particular displays at least will be remembered. These devices are most valuable also in attracting visitors to the museum.

A determined and highly successful effort has been made to keep all descriptive texts in the simplest language. The deadly seriousness which so often marks the effort to portray scientific information is absent to a large extent. Indeed, many of the charts and legends are quite droll, and this effect has been achieved without sacrifice of professional standards.

The German museum probably goes further than public health workers in America would find it judicious to go in its emphasis on physiology and personal hygiene at the expense of community hygiene. It has, however, successfully maintained a balance between the various special hygienes. Such an exhibit gives to the man in the street a means of separating the true from the false and differentiating between the important and the trivial in the health propaganda to which he is subjected

^①Dunham, George C. The International Hygiene Exhibition, A.J.P.H., XXI, 1: 1 (Jan., 1931.)

today from a variety of special interests.

Such a museum established in a large city in America might well become the headquarters for an extensive educational programme comprising both intramural and extramural activities. Among the intramural activities there would be lectures based on exhibits; radio broadcasts as dramatic in their way as the exhibits themselves: specially prepared exhibits on subjects of timely interest, such as influenza and infantile paralysis; and regular courses in hygiene and health education in co-operation with local schools and universities.

If the full value of the museum were to be realised, however, its activities could not be confined to its own building, or its home community. It would, for example, develop small portable loan exhibits for which there is an ever-present demand. Official and voluntary public health agencies have now neither the funds nor adequate experience in exhibit technique to provide sufficient valuable material of this type. Travelling exhibits such as the motorised exhibits of the German museum might well be utilised. In co-operation with state health departments, a number of which are already utilising traveling exhibits, this would provide an admirable method of reaching rural populations. In time these temporary exhibitions might stimulate the development of a number of permanent museums, locally financed.

The question of financing such developments is one that we do not propose to raise here. Support has been forthcoming in the past for worthwhile projects. And if professional health educators in America earnestly desire such institutes for health education, and adequately voice that desire, undoubtedly support for them may be had in the not too distant future.

If we are to reach the masses, we must enlarge our view of the size of the job that confronts us. We cannot leave off with any temporary popularisation of a few simple ideas. The task must be institutionalised. All phases of the health education movement must be utilised in concerted effort. New and effectual methods must be devised and continuously utilised in educating the whole mass of the population, generation upon generation, as to the importance of achieving, and the methods for achieving that summit of racial well-being which the researches of pioneers have made distantly visible. It is believed that museums of hygiene would serve as permanent centres for research and experimentation in health educational methods and as a continual inspiration to reference sources for health educators. The concept of a national network of such institutions, serving in concert as a far flung, permanent and living force for the dissemination of health knowledge among the masses, is noble in purpose and inspiring to contemplate.

(American Journal of Public Health, January, 1932.)

Seaside Bathing

About 200 years ago someone discovered the seaside as a health resort. The discovery was exploited. Seaside hospitals were built in the nineteenth century. And at the present time the shores of many countries are punctuated by therapeutic establishments and countless hotels and lodgings for the healthy and for convalescents. Every year millions trek from the towns to the seashore for their summer holidays.

Some of these millions are carefully supervised. There are the definitely tuberculous, for example. They are medically examined at home, and on reaching the seaside they are usually admitted to special institutions under the control of doctors who have specialised in tuberculosis. So far so good.

But what of the tens of thousands of delicate children sent every year to the seaside without any medical supervision whatever? The parents often have a blind belief, amounting sometimes to an obsession, that if only they can save enough money to send their delicate child to the seaside for a few weeks in the summer, he or she is bound to return full of radiant health and energy. The seaside is in their eyes almost as unerringly effective as a penny-in-the-slot machine.

So off the children go. They may be nervous, rheumatic or subject to catarrhs. Their circulation may be so defective that exposure to the cold turns them white and blue. But they are often indiscriminately herded with robust and perfectly healthy children, and made to follow the standard conventions of the seaside in the summer.

What are these? The child is hustled into the water irrespective of its temperature, of the weather, without any gradual preparation and hardening. Several baths a day, each much too lengthy, are varied by endless paddling by the seashore in the flimsiest of garments though the

wind may be high and the day cloudy. It is doubtful if even the most robust children benefit from this Spartan treatment. The rest suffer, some only temporarily, others permanently.

The remedies for this unsatisfactory state of affairs begin at home. Parents may find it advisable to consult their doctors, and the suitability of each child for a seaside holiday may be discussed with him. The discussion may end in the whole family spending its summer holidays inland, in the mountains, perhaps. Or it may end in the family going to the seaside, but with a string of injunctions and restrictions to be practised by its more delicate members.

Arrived at the seaside, the family may find it has been fortunate enough to choose a resort which has studied this problem carefully and spent much money on finding solutions to it. Some resorts have constructed shallow, salt-water bathing pools protected against the wind, where the temperature of the water is several degrees above that of the sea. Other resorts provide special hot sea-baths for those who are unfit to stand the rigours of ordinary sea bathing. Others provide shelters in which the bather can restore his circulation by hot drinks and hot foot-baths. Still others publish rules and hints for bathing suitable for the climatic conditions of each place.

All these provisions and precautions show that we are beginning to learn the object lesson provided by the poor child, unclimatised and unwilling, who is hurried off into the sea, regardless of its temperature, and is left there till chilled to the marrow! But we are only beginning. Any thoughtful and observant person who spends an hour or two on almost any beach will not fail to discover some mortals, adults as well as children, trying to look well and happy, but utterly failing to do so. How can they look well if their

cheeks are white and their lips are blue? And how can they feel happy if they are shivering all the time, from top to toe?

Some families may find a useful compromise in taking quarters a few miles inland. Here they are out of earshot of the sounds of the sea—sounds which are disturbing enough to provoke troublesome sleeplessness in some cases.

The journey, only on sunny days, of a few miles to the sea is an automatic check on the unrationed bathing and paddling in which those children are tempted to indulge who live within a few yards of the sea.

In many cases the parents would do well to secure the advice of a doctor on the spot. Medical practitioners in seaside resorts have a unique knowledge of their dangers as well as of their advantages. Summer after summer they have had to deal with the crop of gastro-intestinal

disturbances, bronchitis, rheumatic and other ailments which indiscriminate sea bathing yields. So they are well qualified to deal with a problem which has, as a matter of fact, become so insistent that a special discussion was devoted to it in 1931 by the British Medical Association at its annual meeting at Eastbourne on the south coast of England.

The publicity given to this problem has already helped materially towards its solution. Parents and others have only to be taught that shivering, blue and white children on the seashore are unwell and unhappy and that there are simple remedies for this state of affairs, and in due course we shall find these children pink and well. The blue and white child is not an essential and inevitable feature of the seashore. He is just a reminder that "someone has blundered."

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Recent Advances in Obstetrics—Concluded

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The Post-Partum Period

The period following delivery is another field of preventive medicine that should be developed more thoroughly. Every obstetrical patient should be treated with the same careful aseptic technique, as a patient requiring major surgery. Antenatally, foci of infection in teeth, tonsils, sinuses, kidneys should be cleared up. Every precaution should be employed to prevent infection during delivery, by contamination or by the introduction of pathogenic bacteria into the birth canal and no carelessness should be permitted to contaminate the patient as soon as she reaches her bed. Neither doctor, nurse nor other attendant with any infection of the nose and throat or body, should be permitted in the hospital ward. Sterile vulva pads and pitcher irrigations guard the open wound, prevent infection and add cleanliness and comfort. Conserva-

tive treatment with rest, food, sunshine, posture for drainage, ergot and good nursing care will yield the best results.

Sleep and Pain, morphia or codeine are good following delivery for the necessary relief of pain. Sleep should be produced if necessary by a sedative, especially for the first three nights.

Bladder and Bowels: Catheterize, completely, after twelve hours, only if necessary after all attempts to induce have failed. Mineral oil morning and night activate the bowels or an occasional S.S. enema.

Exercise and Posture: With free movement in bed accomplish four things: Drainage—leading to less infection, better circulation—leading to better involution—prevention of thrombosis and a general improvement of the muscle tone. A back rest on the third day, knee-chest position each morning after the sixth day,

bed calisthenics, out of bed on the tenth day.

Examination is made previous to leaving the hospital on the fourteenth day. Backache with longer bleeding suggest retroversion and may require pessary insertion. Subinvolution and cervical tears are considered. A final examination is made at end of six weeks, including blood pressure, urinalysis, blood count, if necessary, weight and bimanual pelvic examination.

Intermediate Period: The young mother when arriving home is closely confined with a new responsibility. She needs intelligent help. Her nursing problems can be dealt best with by a well-trained nurse, for a time, who is in touch with the obstetrician, and here in Canada fortunate indeed is she, who is in touch with the Victorian Order of Nurses. A practical nurse is sometimes competent, relatives are often unaccustomed to present day routine and technique.

Complications

Hemorrhage Vaginal: The three great causes of maternal deaths in obstetrics are hemorrhage, infection and toxemia. Vaginal hemorrhage may be prevented by good anaesthesia, by prophylactic forceps delivery, or with episiotomy, after the head has reached a safe level, to prevent uterine atony and maternal or fetal exhaustion; making certain of no retention of placenta, membranes or clots, by immediate repair of cervical or perineal laceration, by giving pituitrin immediately after birth of baby, by fundus held immediately and massaged if necessary, by administering pituitrin and ergot, by packing uterus if necessary, by glucose intravenous or transfusion, if indicated. In anemia the blood should be typed before delivery.

Puerperal Sepsis: Prevention always outweighs cure. Avoid contaminating the patient. Isolation, with good symptomatic nursing, fresh air and sunlight, Fowler ducubitus with change of position, forced water drinking, easily digested food, tonics,

ice, narcotics, assisted by transfusions, scarlet fever antitoxin, various intravenous antiseptics or milk injections intramuscularly, help.

Shock: Regardless of cause—hemorrhage or protracted delivery attempts, requires instant proper nursing and medical treatment to save life—lower patient's head and shoulders, cover with hot blankets plus hot water bottles, stimulating hypos, with sedative-morphia, intravenous of gum-glucose preferable or blood transfusion or glucose or sub-mammary saline, while waiting.

Pituitrin is one of the most dangerous weapons used in obstetrics when in indiscriminate hands, but when administered judiciously and cautiously in small and frequently repeated doses before delivery, offers a safe and affective method of inducing and shortening labour at term. It is used extensively in the third stage after the birth, to aid placental separation and expulsion and to prevent hemorrhage. **Thymophysin:** A new combination of extract from the thymus and the posterior lobe of the pituitary is used to hasten uterine contractions but is found unsatisfactory, generally.

The Newborn

Intracranial Hemorrhage in the Newborn is best treated with repeated lumbar punctures, blood transfusions, oxygen if necessary, careful nursing supervision, simulating premature care with little handling and breast milk by gavage.

Asphyxia Neonatorum: Due to pre-natal atelectasis, obstruction due to mucous exudate, meconium, or amniotic fluid or to anaesthesia, cord or central pressure, drugs, etc., is best treated with catheter or intratracheal tube, mouth and pharynx suction, then mouth to mouth insufflation, or inhalation from a small cylinder apparatus of a mixture of oxygen and 7% CO² with mask over face and insufflated under pressure, continued until respiration is established or until the heart has ceased to beat and cynosis has developed.

This inhalation should be given several times a day for 5-10 minutes for several days, to assure full dilatation of the lungs, so, to save many children who now die of pneumonia, consequent upon continuing atelectasis during the neonatal period. Hot and cold tubs are not to be overlooked.

Persistent Thymus is suggested clinically in the first few days after birth by (1) crowing breathing—with brassy cough due to pressure on the recurrent laryngeal nerve, (2) blue spells—due to breath holding or pressure, (3) difficulty in nursing, (4) convulsions, (5) sudden death.

Treatment—immediate, x-ray radiation at weekly intervals for 2-4 times—sometimes 2-3 series are required. It is more common in males, 6-1.

Differential diagnosis is atelectasis, cerebral hemorrhage and congenital heart malformation.

Icterus Neonatorum can be appreciably eliminated by clamping and tying the cord immediately after birth, so lessening the amount of hemolysing placental or cord blood getting into the newborn circulation producing this jaundice. Familial jaundice is best treated with 8 c.c. of whole blood intramuscularly or with injections of mother's serum.

Pemphigus Neonatorum, the bug-bear of hospitals throughout the world, is sometimes present in the newborn at birth. It appears to be carried from hospital to hospital and from pustular infection on some one or thing coming in contact with the baby. Prophylaxis is the best treatment; all healthy babies should be kept isolated in the nursery, to the extent of only being attended by the nurse and being brought individually to an examining room for inspection. As a preventative, six hours after birth the newborn is first given a bath with sterile water, followed by a bath of 1-6000 biniodide, then with a bath of 1½% copper oleate solution. During its stay in the hospital this copper oleate bath is given daily; no

soap is used. On discovery of any pustule the case is isolated, the pustules are immediately broken and touched up with 5% tincture of iodine, baby is kept naked and dry under a heater, with calomel and starch powder applied.

Supplementary Feeding: The daily weighing of baby, with careful notation of the weight and immediate use of good nourishing supplementary feeding, or weaning, where necessitated, before too much weight has been lost, constitutes a great step in the lessening of infant mortality.

Early Pregnancy Test

Is one of the most important achievements in obstetrics in recent times. The Friedman Test for early pregnancy is done by the injection intravenously of small amounts of urine from pregnant women, after about the third week, into an adult female rabbit, which induces ovulation or recently ruptured Graafian follicles, seen macroscopically in this animal, in thirty hours time. This procedure will likely supplant the original Ascheim-Zondek Test where immature female mice are used and the results are not seen for five days time. The test is certain in practically all cases and has been recommended also for the diagnosis of Hydatidiform Mole and Chorio-Epithelioma, where suspected, as it gives a positive result in these conditions too. If, after the removal of the new growths, the test becomes negative, a good prognosis is given; if, however, the test remains positive for a long time, it is indicated that all the disease has not been removed, or that a Hydatidiform Mole has become converted into a Chorio-Epithelioma or that a recurrence has taken place.

Birth Control

It seems, is a doctrine which applies to the wrong element of the population, resulting in the gradual extinction of the old families, while the more precocious Europeans with ten children to the family, will, in a few generations constitute numerically the first families of the nation.

Unfortunately, knowledge given in these cases, in which it may seem necessary, is not kept secret by the immediate recipients, but is imparted to others who have no just excuse for the avoidance of childbearing. We are morally responsible for imparting knowledge, which we know will be used for evil. The training in sex education should begin in the school in a healthy, clean study of the matter as part of biology and advice should be restricted to individual cases as a medical and not as an economic measure.

Rectal Ether Analgesia in Labour

Of recent years great success has attended the efforts to relieve the pain during labour. Patients are now demanding relief and this is as it should be. Too long has the agony accompanying childbirth been looked upon as "nature taking its course." It seems that at last woman is coming into her own in this regard. While neither patient nor surgeon would think of an appendix removal without complete relief from pain—a relief for a brief space of perhaps fifteen minutes or more, does it not seem ridiculous to allow unfortunate women to undergo the torment of the damned for hours or maybe days in labour? By this relief from suffering in childbirth, the world should be better, the children healthier, the mothers happier and much of the illness and invalidism of the later years of life would be avoided.

Rectal Ether Analgesia is induced by the combined result of several drugs working together. The induction involves three or more hypodermic injections and one or more rectal instillations. In practically all cases it affords relief to the agonising ordeal and in a goodly number of cases does offer painless childbirth.

Before beginning the treatment, the obstetrician should carefully explain to the patient that her co-operation will result in the relief of pain, that she will fall asleep and likely not waken until after the baby is born. The simple technique is as

follows: The perineum is prepared and an S.S. enema given, if not too far advanced. When the pains are coming at five-minute intervals and the cervix is at least two fingers dilated, the patient is given, in the gluteal region, the first hypodermic of morphia, gr. $\frac{1}{4}$ in 2 c.c. of a 50% solution of magnesium sulphate (obtainable by ampule). The patient is advised to try to remain quiet, go to sleep; cotton pledgets are placed in her ears, the eyes are covered with a towel, the room is darkened, curtains are drawn or lights subdued. The window is closed, all manipulations are gently and quietly done, any talk is in whispers, the patient, if talkative, is not answered. The instillation is given in about twenty minutes, for which the patient is turned on her left side with knees flexed and the area surrounding the anus is smeared with vaseline, to assure no irritation if expelled. The instillation apparatus consists of a four oz. enamel funnel attached to twenty inches of rubber tubing connected with a glass connecting tip to a stiff French catheter No. 22. The ether mixture consists of quinine, alcohol, ether and liquid petrolatum. A glass of four oz. of warmed liquid petrolatum is also at hand. On commencing the instillation, about one oz. of the liquid petrolatum is poured into the funnel, and just as it runs out of the catheter, the tubing is pinched off.

Method of Instillation: The doctor inserts the vaselined, gloved, right index finger into the rectum and the lubricated French catheter is followed along this for eight inches or more to assure its being inserted above the presenting part, otherwise, if the catheter curls up, the instillation will be expelled. The nurse now pours the ether mixture of four ozs. into the funnel and it is slowly run by gravity into the rectum between pains. During a pain the tube should be clamped, the patient is advised to try and "tighten up" on the rectum, not to press down and to breathe

through her open mouth and make every effort to retain the instillation. In larger, stronger or excitable patients more than four ozs. is best used. When the funnel is almost empty of the other mixture, quickly add an oz. or more of the liquid petrolatum to assure the patient's getting all the solution and to prevent entrance of air. The nurse then clamps or squeezes the tube and with a large folded towel, presses strongly on the perineum to assist in the retention, especially during a strong pain; then the catheter is quickly but gently withdrawn. Towel pressure for at least ten minutes is one of the most important features on which the success of the analgesia depends. The intelligent co-operation of the nurse or attendant in maintaining silence and leaving the patient alone, not holding her hand or rubbing her back, is one of the key notes of success. After the instillation the patient is given the second hypodermic of 2 c.c. 50% magnesium sulphate solution, the synergist, to prolong the action of the ether. The patient may be turned on her back or left on the side and she is made warm with blankets. In a half hour's time the third hypodermic of magnesium sulphate solution, to deepen the effect, is given.

*Results of the medication vary from a sedative effect to analgesia, with unconsciousness and complete amnesia. While instilling, the patient may drowsily remark the taste of ether in the mouth—often, even before the whole instillation is given, the patient falls asleep, pain is eliminated, labour progresses, the contractions ensue, sometimes accompanied by slight murmuring or restlessness. After she remembers nothing from the time of first instillation until she awakens in her room after the delivery is all over. Sometimes one instillation is sufficient to obtain quite wonderful relief—relief to the patient and also a very satisfying relief to the obstetrician and to the nurses. After instillation, relief is

obtained for varying lengths of time, according to the patient's nervous makeup, to the progress of the labour and to the ability of the nurse: a quiet, stable patient generally gets better relief than the neurotic or non-co-operative one. Freedom from complaints of pain may be from three to six hours ordinarily, accordingly, but the instillation may be repeated if necessary at intervals of three hours or more, three, four or five times with absolute safety. A vaginal or rectal examination may be done in fifteen minutes or better later, to avoid stimulation of expulsion and disturbance. During the progress of the case the nurse may examine the patient for progress; that is, perineal bulging, but not unnecessarily. On moving the patient on the stretcher, she should be lifted and her aid not sought; to prevent rousing, her eyes should be protected against a strong electric light, and the same quiet stillness maintained during her preparation and delivery.

After using this method of analgesia one is conscious of a certain feeling of guilt on hearing the shrieking agony of the unrelieved in the labour room. Today women may be carried through labour with little murmuring and no shrieks. With this rectal synergistic analgesia there is absolute safety to both mother and child. In uterine inertia, as is self-evident, the instillation is contra-indicated. In any case where labour stops, you must simply wait until it begins again and repeat the technique when you know labour is advancing. It is seldom, however, that labour stops or is delayed by the instillation if given at the proper time—not too early. Sometimes quinine gr. v. or gr. x. in capsule may be given by mouth before the instillation or between instillations to promote contractions. This ether-oil method can be used in all normal cases, the same in the primipara as in the multipara, in dystocia, in induction, in toxemias, in cardiacs, in nephritics and in tuberculous conditions. From an economical standpoint this method

does away with considerable expense and can be used in the home with good results and does not require the services of an anaesthetist or the use of an expensive anaesthetic. It does not require more nursing or medical attendance than is necessary for the safe conduct of labour anywhere. This synergistic method is particularly adapted for the patient who has passed through difficult and painful labours before and is in persistent terror of the coming pain. The patient's knowledge during the antenatal period that at the end she is assured of being relieved of pain is invaluable—she does not look ahead in fear and dread of the ordeal. Her energy is conserved as she has not been shocked. She not only looks infinitely better, but she feels much better and may get out of bed earlier than the one who has not been so fortunate. The patient, with her pains alleviated, may be under the anaesthetic during the whole labour of many hours. There is no increase in operative deliveries, in post-partum hemorrhage or in the stillbirth rate; there is better relaxation and there is no interference in any way with the normal process of labour.

As to inconvenience, most of the so-called disadvantages are due to faulty technique, the commonest of which is probably the improper catheter insertion, due to failure to insert the French catheter above the presenting part—it curls up and with the advent of a pain the retention enema is expelled. Occasionally an unexpelled preceding S.S. enema may cause expulsion and necessitate another instillation. The instillation must be given best before the patient is too far advanced in labour or is fully dilated—before the pains are too strong and bearing down, as otherwise it is impossible to subdue the pains and difficulty is reached in the patient retaining the instillation. The towel perineal pressure for ten or fifteen minutes is essential. Sometimes the patient complains of a slight burning sensation in the anal region immediately after the rectal instilla-

tion. Well vaselining the part will prevent this, but if the technique is followed, no inflammation, of even a mild type, occurs. Extensive hemorrhoids, without abrasions, are not affected and do not contraindicate this method. Poor results, however, undoubtedly occur from attempts at modifying or entirely disregarding the simple rules of administration. Minor symptoms of ringing in the ears and temporary deafness, as is ordinarily resultant from quinine, is sometimes observed. The patient in the home should be carefully watched, especially the multipara, as labour may advance and terminate very quickly while the patient is fast asleep. While a nurse is preferable at home, an ordinary attendant is quite satisfactory, as the patient practically never becomes noisy or troublesome, necessitating extra help. Vomiting is occasional, but not more than with any other form of anaesthesia. This method takes a little time, but the very desirable results obtained will more than compensate the obstetrician when the new mother voices her appreciation.

In my series of 540 private cases using this method of rectal analgesia, I have yet to see any ill effect. Practically all the cases were in hospital, in each of which I have had the excellent co-operation of the nursing staffs. In 98% of 540 cases, pain was greatly alleviated: of these, 67% had practically no pain, while 31% obtained very considerable relief, but not to be graded perfect, and in 2%, due to instillation expulsion or to labour being too far advanced, the patient obtained no relief from this method.

Where such safe relief is obtainable, this method can be recommended for more universal use, both in hospital and in home deliveries.

The word of the patient after delivery is the best criterion as to its worth and the finest recommendation that can be given this method of pain relief.

(Address read by invitation before the Registered Nurses Association of Ontario at Ottawa. January 28th, 1932.)

A Brief Resume of the Report of the Lancet Commission on Nursing

By MARION LINDEBURGH, Assistant Director, McGill University, Montreal, Que.

An editorial appeared in *The Canadian Nurse* (October, 1931), which presented initial information regarding the appointment, aims and function of the Lancet Commission on Nursing in Great Britain. This article referred to data made available in the first and second interim reports of the Commission, as published in the February and August issues of *The Lancet* during last year. The final report is now completed and may be obtained from The Lancet, Ltd., 7 Adam Street, Adelphi, London, W.C.2. The price, including postage, is 2s. 9d.

It is not the objective, in presenting this review, to undertake a critical or comparative analysis of the Lancet Commission Report in relation to the Survey Report of Nursing Education in Canada, but rather to indicate certain significant features within the Report itself which seem to constitute the most immediate problems in the nursing situation in the British Isles. The two reports present many points of similarity and many points of contrast. A study of these comparative and contrasting features should establish a mutual interest and breadth of understanding relating to nursing problems in Great Britain and Canada.

It is of unique significance that at approximately the same date nursing has reached a crisis in its development in Canada, Great Britain and the United States which has demanded an analysis of existing difficulties. An urgent need has arisen in the hospital nursing school for reconstruction in the administration and function of its two major responsibilities, nursing education and nursing service.

In contrast to the immediate nursing problems of "over-production"

in Canada, the Lancet Commission was appointed "to inquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women suitable for this necessary work."

The Commission, under the chairmanship of the Earl of Crawford and Balcarres, P.C., K.T., F.R.S., was appointed in December, 1930. The personnel of the Commission was representative of the nursing and medical professions, the field of secondary and college education, social economics and hospital administration. The personnel and function of this committee is in contrast to that of the Canadian Survey, in which a committee, composed of members of the Canadian Nurses Association and the Canadian Medical Association, assigned the study to an educational survey expert who, as Director of the Survey, became solely responsible for the analysis and the final recommendations.

The Lancet Commission was extremely fortunate in securing the cooperation of Dr. Bradford Hill, of the Department of Epidemiology and Vital Statistics, London School of Hygiene and Tropical Medicine. To Dr. Hill is given the credit for the careful compilation of data and statistical presentation. The Commission held its first meeting on December 8th, 1930, and during the following fourteen months involved in making the survey, twenty-four meetings were held.

As in Canada, the Lancet Commission adopted the questionnaire method. There were, in all, three questionnaires, and it is significant

to note that they related directly or indirectly to the problem of hospital nursing service. Unlike our survey, which is focussed primarily upon problems relating to the education of the nurse, the English study is avowedly concerned with the question of the actual care of the patient in the hospital ward. To quote from the Report, "To restore the popularity of nursing among educated girls has been the chief objective of our inquiries. The economic and administrative difficulties of hospitals, the vocational ideals of some nurses, and the professional aspiration of others concern us only in so far as they promote or hinder our object of inducing enough educated girls to come forward and dispel anxiety about the nursing care of the sick in hospitals. . . It is useless to provide hospitals and doctors for the sick, unless an adequate nursing service can be assured."

A sub-committee was appointed to draft the first questionnaire. Its content of thirty-six questions was selected to ascertain (1) Whether shortage related to candidates for training or to trained nurses for staff positions—or both; (2) Whether shortage was felt in hospitals approved by the General Nursing Council as well as by those not so approved. This questionnaire was forwarded to responsible authorities in approved training centres, and a selected number of questions to hospitals not approved. Two further questionnaires were sent out, respectively, to trained nurses working in hospitals, and to a selected number of student nurses (known as "probationers" throughout their entire terms of training), with secondary school standing.

In addition, groups of girls still at school were questioned. The results of all these inquiries are summarised in the appendices of the Report. Response secured from questionnaires was such that information received on conditions in Scotland and Ireland was not sufficiently adequate to enable general conclusions to be formulated. Thus the Report in its final

form deals only with conditions in *England and Wales*. Furthermore, the Report is based on data secured in the first half of 1931. The effect of the economic depression in England, as elsewhere, resulted in a sudden influx of applicants to hospitals which modified to considerable degree a situation which but six months previously demanded urgent attention. In this connection it must be noted that, regardless of the change that suddenly came about in the problem of shortage of candidates, the responses received from matrons, sisters, staff nurses and probationers were of such value as to convince the members of the Commission that there was still need for certain fundamental adjustments in hospital nursing schools which must be made in order that *desirable* candidates be secured and retained.

During the course of the survey Dr. Hill prepared two interim reports, presenting a statistical analysis of data secured up to date. No comments whatever were included in relation to conditions revealed. These reports were of specific value to the Commission in directing their future inquiries and in making available, to associations and individuals interested, the progress of the work of the Commission. The final Report presents a complete statement of findings in statistical form. Tables and graphical representations are clear and comprehensive. The major part of the Report deals with the Commission's interpretations of data secured, and the field of discussion is classified under twelve sections.

Recommendations are assembled under sections dealing with reasons for shortage of candidates and trained staff for general duty, and positions of leadership in nursing service. In the last section a well consolidated summary of recommendations is presented. The Commission emphasizes the fact that in making these recommendations attention has been confined to proposals which involve certain possible *adaptations*, rather

than with fundamental changes in the present system of hospital administration in which nursing schools are profitably maintained for the sole purpose of securing nursing service.

Following this general statement suggesting the aims, organisation and method of function adopted by the Lancet Commission, it would seem advisable to devote some attention to the nature of the response to the questionnaires, and the recommendations which follow.

Shortage of candidates, in quantity and quality, is clearly evident in returns of questionnaires. Taking the hospitals collectively, one-fifth of them fail to secure suitable candidates as "sisters" and one-half fail to secure staff nurses and probationers of the standard they require. Shortage is much less acute in the London voluntary hospitals than in other groups. The difficulty in securing properly qualified students is revealed in the fact that one-third of the hospitals will accept candidates who have not passed beyond the seventh standard of the elementary school. Real difficulty is experienced in securing candidates with secondary school education. The following extract of a report of an Education Committee of a certain county confirms this statement. "It is perhaps a little disappointing that only six girls out of seven hundred and forty took up nursing." A report from the heads of eight secondary schools shows that during the period of ten years the number of girls entering nursing was under fifty, an average of less than one candidate per year per school.

Replies received from probationers reveal fewer points in favour of nursing than were listed under objections. The following are some of the points of disfavour: limitation of opportunities for social life; shortness, irregularity and uncertainty of off-duty time; over work and fatigue; lectures during off-duty time; too much menial work; excessive respon-

sibility before receiving adequate instruction; unnecessary restrictions and discipline in "Nurses' Home;" favouritism shown by the sisters to students; poorly cooked food; insufficient sleep; lack of interest shown by the hospital in the health and welfare of nurses; burden of work and study too great; narrowness of outlook and continuous "shop."

Answers to questionnaires received from staff nurses expressed many reasons for reluctance to remain in hospital positions. The following were mentioned the most frequently: poor salary—better remuneration in fields of specialisation in the community; long hours of work; lack of freedom during off-duty time (permission necessary if remaining out after ten or eleven p.m.); opportunity for social life no greater than that afforded to probationers; lack of recognition, on the part of authorities, of potential qualities of leadership—little opportunity for promotion.

Information from other sources revealed certain basic reasons which are influencing factors in retarding the professional growth of nursing in hospitals. The following are of special significance:

The profession still judged in terms of conditions of its past.

Fields of specialisation offering more favourable vocational opportunities.

The attitude of certain nursing members in authority who still hold to the belief that the nursing spirit and nursing skills have been *dimmed* by the introduction of the "curriculum" and who still adhere to long hours of faithful nursing service, predicting that less autocratic discipline and provision for greater social freedom would prove fatal to the profession.

The undemocratic attitude in professional relationships—students disparaged by their seniors, and sometimes rebuked before the patients.

The employment of untrained or partially trained women by doctors,

by hospitals, and by the public, is a source of grave dissatisfaction within the profession.

The gap between school leaving age and the age approved for entrance into nursing schools. In this connection the Report contains certain proposals and schemes to provide for continued secondary school education or preliminary employment, which would facilitate the selection of young women suitable for the profession. The College of Nursing favours the establishment of a pre-nursing course, in connection with certain recognised hospitals, and operated in co-operation with educational authorities, which would not only fill the gap but would provide a stronger educational background. A draft syllabus of such a proposed course appears in appendix V of the Report.

In view of the fact that twelve different classifications of hospitals were used, the data secured and tabulated in comprehensive tables and graphs indicates marked contrast in standards. Therefore the Commission has attempted to focus attention to the medial conditions of service in setting up recommendations. The following picture is presented by the Commission to suggest the average existing situation in approved schools:

"The candidate for nursing must be 18 or 19 years of age before she submits her application, though she may be accepted at 17 if she is willing to enter a hospital that is unable to give her a complete theoretical and practical training. She should have had, if she wishes to enter the voluntary hospital service, an education at a secondary school, and possession of the Matriculation or School-leaving certificate will assist her to gain an entry into one of the larger training schools. On the other hand, in the absence of a secondary education, she will have no difficulty in gaining admission to a municipal or mental hospital if her educational level is that of the seventh standard

at an elementary school. Having secured admission to a hospital approved for training she will usually find herself provided with a separate bedroom; but in any hospital in which an approved course of training is not given it is probable that she must be content to share her room. She must, if she wishes to be fully qualified, undergo a three to four years' course of training and, concurrently with her ward work, must attend lectures, in the morning, afternoon, or evening, half of which she must attend in her off-duty time. Rarely will she be required to pay any fee for her training, and she will not, as a rule, be asked to bind herself to work for any further period after qualification in the hospital which has offered her her training. During her tuition she will be in receipt of a salary, ranging from £20 to £30 per annum in her first year to £30 to £40 in her final year. In addition she will be provided with her board and lodging, her uniform, and her laundry. When she becomes a staff nurse her initial salary will be £50 to £65 per annum, and should she become a Sister her salary will rise to between £70 to £85 and continue to increase by annual increments to, perhaps, £100 per annum. In two-thirds of the hospitals to which she may go after qualification she will be able to contribute to a superannuation scheme, and thus make some provision for her future.

"Her life will be an institutional one, and during her training at any rate she must, when she is allowed out, return to the nurses' home by 10 p.m., unless she has special permission to be later. After qualification her hour to return in some hospitals may be a later one, but her hours will be fixed, and she will not be provided with a latch-key. Within the nurses' home she will have a common room at her disposal, but, as a rule, she will not be allowed to introduce men guests. Facilities for indoor and outdoor recreation will be given her (especially tennis), and

she will usually be permitted to smoke in some part of the nurses' home. In return she will work from nine to ten hours per day from between 7-7.30 in the morning to 8-8.30 at night. During this day she will have half an hour off-duty for her lunch and her tea and, probably, a quarter of an hour to a half hour for an early lunch, while she will have a further two to three hours of free time daily. Weekly she will be allowed half a day or a whole day off, and she will usually be allowed some extra time off fortnightly or monthly. As a result her *average* working week on day duty will be between 55 and 64 hours. Annually she will be given (as a probationer) two to three weeks' holiday.

"With regard to making plans for the use of her off time, she may have as little as a month's notice of this annual holiday; her half-day or day off weekly she will know at the beginning of the week, or, less frequently, at the beginning of the month; her daily hours off she will know often only at the beginning of the same day.

"When she is on night duty her hours will be from 8-9 o'clock at night to 7.30-9 o'clock the next morning. Sometimes during this time she will be relieved and be given some free time away from the ward, but in an equal number of hospitals she will have to attend to her duties throughout the night. She will be on night duty for three months at a time, and during this period will be allowed two to four nights off per month in addition to coming to duty later on occasional evenings."

Recommendations are systematically formulated in connection with points of issue as revealed by the survey. The Commission has endeavoured to suggest measures which would meet the peculiar differences in general and special institutions. In all, 61 recommendations are presented. Space does not afford full publication, but the following are

selected to indicate the nature and scope of the adjustments suggested:

"I. Conditions of service in the nursing profession should be altered in such a way as to attract a far larger proportion of those girls who in any case will stay at school till they are 18.

"V. Hospitals should realise that the nurses are paying indirectly if not directly for their training and that the onus rests on the hospitals to provide good facilities for such training including expert instruction during hours on duty. To this end a ward sister who has to train successive batches of students should be given extra remuneration, and some relief from other duties, for teaching in the wards.

"XII. We recommend the universal adoption of the College of Nursing scale of minimum salaries for posts higher than that of the ward sister. . . .

"XIV. All voluntary hospitals, institutions and associations employing nurses should participate in the Federated Superannuation Scheme for Nurses and Hospital Officers.

"XVII. Day Duty — the span of work should not exceed 13 hours.

"XX. Not less than three clear hours off duty independent of meal times should be allowed during the span every day.

"XXII. The hours of night duty should not exceed 57 in any week.

"XXVII. No nurse except a night sister engaged as a permanent officer, should be on night duty for more than three months in any year.

"XXX. The matron should have the power to suspend, but not to dismiss, a probationer pending investigation by a committee of the Board of Management.

"XXXI. A separate bedroom should be provided for each nurse. . . .

"XXXV. Off duty time should be arranged in advance, so that the probationer knows at least a week beforehand, between what hours she will be free on a given day.

"XXXVI. A probationer on day duty should be free to go out between the time she comes off, and bedtime, without special permission.

"XL. The preliminary state examination of the General Nursing Council should be divided into two parts: Part I. Anatomy, Physiology, Hygiene; Part II. Theory and Practice of Nursing.

"XLIV. Questions in the final state examinations for all parts of the register should be confined to nursing treatment, and should not involve systematic medicine, surgery, gynaecology, or psychiatry.

"XLVII. Sister tutors should not be required to undertake any duties other than those connected with education.

"XLIX. A redistribution between nurses and ward maids of the domestic work in the wards of hospitals is urgently required.

"LIII. Posts as staff nurse should be reserved for fully trained nurses.

"LIV. Hospitals which are not approved by the General Nursing Council should not seek to enlist probationers for training but should be staffed by trained nurses and domestic workers."

An editorial appears in the March issue of the *British Journal of Nursing* in which a criticism is presented regarding the recommendation concerning "registration" which suggests the placing of part of the "Preliminary State examination out-

side the control of the General Nursing Council." The principle of supreme importance underlying the Nurses Registration Acts in Great Britain is the admission to the State Register through the "One Portal." It is regretted within the profession that in mental hospitals there still exists two accepted forms of qualification; through the General Nursing Council and through a certificate issued by the Royal Medico-Psychological Association. Further regret is expressed, in that no recommendation is made by the Commission in connection with the Inspection of Nursing Schools by registered nurses as well as by medical practitioners.

A very real interest has been taken among nurses in the British Isles in the work of the Commission. During the study a memorandum of suggested changes was submitted to the Lancet Commission, for consideration, by a group of nurses, many of whom had followed the International Courses organised in London by the League of Red Cross Societies. Their concern as to the attitude toward nursing held, not only by the public, but by hospital authorities, is expressed in the character of their recommendations. Nursing leaders in England, as in America, are becoming strongly aware of the fact that nursing schools must be placed upon a more favourable financial and educational basis, in keeping with modern educational standards, if nursing is to receive professional recognition.

Nurses' Christian Fellowship

During the past few years there has been much improvement in the provision made for the intellectual and social needs of the student nurses, e.g., better teaching facilities and the shortening of the hours of duty. But what has been done for the spiritual needs of their lives? Oh, that leaders would arise in the profession to help nurses to satisfy that heart-hunger present in each one!

Is there any nurse who cannot remember when, in her training school days, she felt it difficult to adjust herself to the "new order of life," and how lonely she felt at times for the old associations in spiritual things, the old companions and places which had so richly helped her in the past—her church and the fellowship with Christian friends?

One came away from graduation, having gained a diploma, but with a sense of having lost something—that something which a nurse really needs to help her to go out into the world to minister to the suffering and afflicted, and to lift the fallen, in the practice of her profession.

That something can be described as "a consciousness of fellowship with Him, who is Redeemer and Creator."

During the past year a movement has been started to form a "Christian Fellowship for Nurses." It is believed that there are small groups of nurses in various cities throughout Canada who are meeting together from time to time in their own training schools, or perhaps outside of training schools, for the purpose of securing fellowship in spiritual things and by companionship to encourage and strengthen one another to maintain their hold on the vital things of life—those things pertaining to eternity.

In Toronto, during this past year, a group of nurses has been meeting

together once a month (or oftener) for the purpose of Christian fellowship. Mrs. F. Noel Palmer, who is joint secretary with her husband, the Rev. F. Noel Palmer, of the Inter-Varsity Christian Fellowship of Canada, has been very kind in opening her home for meetings. Also Mrs. Maud Howe, secretary of the Canadian Christian Crusade, has opened her home and has given freely of her time. Both these ladies are standing whole-heartedly behind the movement and are the inspiration of the group.

While this group is organised similarly to the Inter-Varsity Christian Fellowship, the Nurses' Fellowship is organised and conducted by the nurses themselves. It is inter-denominational. Its aim is to encourage individual and collective prayer and Bible study among nurses, graduates and students in training.

There is no detailed programme planned, but the guidance is sought from the Leader, the Lord and Saviour, Jesus Christ. Friendly informality and spirituality are the outstanding characteristics of the meetings. New acquaintances are made, with free interchange of experiences, hopes and aspirations; for some meetings special speakers are secured, at others the nurses' talent is used. They sing, have the reading of the Scriptures, receive requests for prayer, hear of answers to prayer, and then at the end of the meeting refreshments are served.

This delightful fellowship with one another is enjoyed, as all are "one in Christ Jesus."

The nurses realise the fact that union means strength; they would like to get in touch with others and hear how they are getting on. Perhaps others would be interested in starting something similar in their own groups. Correspondence is invited.—ETHEL E. CHILVERS, Reg.N., 278 Bloor Street East, Toronto, Ont.

A Symposium on the Administration of Student Field Work

[Editor's Note: For students enrolled in the Department of Public Health Nursing, University of Toronto, a continuous period of nine weeks of field work is arranged. The time is spent with two of three agencies: The Provincial Department of Health; The Municipal Department of Health, and The Victorian Order of Nurses. Prior to that period a conference of representatives providing field work is arranged by the Department of Public Health Nursing of the University of Toronto. This year a Symposium on the Administration of Student Field Work included several brief papers. A synopsis of these is published.]

I

Plans before the Field Work Period from the Standpoint of the Supervisor

By JESSIE M. WOODS,

District Superintendent, Department of Public Health, Toronto, Ont.

Selection of District: In planning for the field work of students, careful selection of the type of district is important; one that will give the student an opportunity for observing every type of activity carried on by the nurse and later for carrying on independent work; and one that will give as even a division as possible to school and district work. It is well to have the student carry on field work in a district where she will have contact with the independent, teachable type of family as well as with the more difficult type presenting social problems, where health teaching is carried on under difficulties.

Selection of Nurse to whom Student is Assigned: In choosing the nurse to whom students are to be assigned the following points should be kept in mind: the interest of the nurse in the work of students, her ability to teach, to plan and to direct their work. The nurses who have these qualifications, however, are not always the ones to whom students are assigned as their districts may not be the type best suited for field work.

Preparation of the Programme: The nurse should be notified well in advance that she is to have a student. A conference of the staff nurses selected and the superintendent should be held before the students arrive, to discuss the nurses' plans for direction of students' work and

the supervision to be carried on by the staff nurse and superintendent in schools, district and child health centres.

A regular time for conference of the student and the superintendent, once a week if possible, should be arranged before the students arrive. The staff nurses having students should be prepared to be present at such conferences for part time at least, although this may not be possible for them every week. The superintendent should plan to see the student daily if possible and give her an opportunity to discuss individual cases or problems.

Obtaining Co-operation of Those who Contribute to the Programme: Nurses having students should explain previously to their school principals and teachers who the students are, why they come and what it is hoped to give them.

In the homes selected by the nurse for close follow-up work by the student it is well to prepare the family for the visits of a new nurse. It makes it much easier for the student and family if, on the first visit, the staff nurse is able to say, "This is the nurse who I told you would be visiting you for the next few weeks."

The district medical officer has a great deal to contribute in the way of information concerning the different activities carried on in school, district and child health centres and his help in making the field work of the student of more value should be asked. The child health centre physicians should be prepared for the students in their centres and asked to take time to explain to them the work of the centre.

The secretary of the Neighbourhood Workers' Association should also be notified that the students will be with the district staff and asked if she will tell the students, after they have been there for a few days, of the work of the Neighbourhood Workers' Association and their relationship to other social organisations.

The staff nurses, apart from those to whom students are assigned, should be asked to help the student in every way they can, to show an interest in her work and make her feel that, during the time that she is with them, she is one of the group.

II

Plans during the Field Work Period from the Standpoint of the Supervisor

By MARION STEVENS,

Supervisor, Victorian Order of Nurses,
Toronto, Ont.

The success or failure of the student nurse in the field depends largely upon herself. The opportunity is open to her once she enters the district. After application to studies, her enthusiasm is keen, and she has high hopes that she may be able to apply her knowledge with a measure of success.

It lies within the power of those responsible for her instruction and guidance to preserve and increase that interest. The supervisor may assist, but the real opportunity is given to the staff nurse who works so closely with the student.

Plans have been made weeks in advance after careful consideration and it is the opportunity of the administrator to assist the staff nurse in the meeting of these requirements. The plan is a device which aims towards purposeful achievement and it has been made simple to allow necessary freedom.

For a week or ten days the student should be left with the staff nurse, to find her ground. All types of visits should be observed. Early indepen-

dent and supervised visits should be made as planned. From these visits families of special interest should be selected for study. Emphasis should be placed on the selection, upon the opportunity presented for case study and construction work.

The following of a case from prenatal to postpartum and through postnatal care, affords a good opportunity for experience and has in the past contributed to the success of the work. But since the requirement as a minimum number of these visits is so reasonable, it ought to be possible to select a prenatal in which a special advantage is offered to the student and her plan of activity should not be interrupted, unless the case seems to offer some special interest. Prenatals early in pregnancy give excellent opportunity for health teaching and should be provided. A certain number late in pregnancy should be observed and visited. Confinements and operations should be arranged for each student for observation.

It is important that the student should have opportunity to use a record system and to realise the extent to which it may promote the work.

At the end of a period of practical experience, the student may then be ready to discuss her cases on conference with staff nurse and supervisor. Every opportunity should be given the student to be present when a case known to her may be discussed in short conference with other agencies.

New cases opened should be observed early; independent work of this type gives the student the chance to discover her problems and work out the method of meeting them while the opportunity for consultation is possible. Every opportunity for the student to show initiative should be allowed, at the same time the student should have the benefit of experience in discussion of work and special emphasis should be placed on dangers arising in the treatment of a case. The supervisor may be most helpful to the student when visits are made with her

in the field and should choose those cases where the advantage of an educational visit is offered.

It is important that the staff nurse or supervisor catch the vision of the student whose ideas may differ from her own. There is no desire to curb the spirit of the student whose originality may be purposeful. To the weak student encouragement may be necessary for development.

In administration the plan should include:

1. A sympathetic understanding of the student and staff nurse.
2. The importance of preserving initiative.
3. The value of concentration in co-operative effort.

III

Plans for Initiation and Subsequent Experience throughout Entire Period from the Stand-point of the Staff Nurse

By KATHLEEN McNAMARA,
Victorian Order of Nurses, Toronto, Ont.

Before meeting the student whom she is to introduce to the field, the staff nurse attends conferences relating to the purpose and content of student field work in general and to particular points of routine. She receives written instructions in the form of a schedule as a guide in carrying out the various types of visits. She has information regarding the previous academic and professional education and experience of the student with whom she is to work. Her plan as instructed (the writer speaks in relation to field work with the Victorian Order of Nurses) gives an early introduction to all types of visits and following the observation period the student participating in independent experience and supervision by the supervisor and staff nurse.

Since the staff nurse has been furnished by the supervisor with this written guide as to the types of visits to be made each day; the approximate time when supervised and indepen-

dent visits should be made, the staff nurse's plans and responsibilities in the initiation and subsequent experience of her student would include:

1. Daily reference to this guide and plans to carry out the suggestions contained therein, realising her own definite responsibility for the progress and education of her student.

2. Careful introduction of the student into each home. So much depends on giving her a happy welcome or mere tolerance, which would prevent giving the student a situation in which she might teach and leaving a poor contact for repeated visits to that home.

3. Participation of the student in the Order's contacts with co-operating agencies.

4. Discussion of and participation in patient's records. Here one might well take heed of her own care in recording, for the student has so lately studied in theory the value of records. She must observe and participate in careful recording from the beginning of her practice work if one expects continued care in this regard throughout subsequent experience.

5. Frequent reference to her own practice sheet (the student's record of field work for the university) to be sure that all types of visit and supervisions are being included and not left over until perhaps hurried visits would be made just at the conclusion of the field work period.

6. An open mindedness in discussing cases in her district to which the student has been assigned, or has met with the staff nurse—allowing her a feeling of reliance on her own initiative and work. One has visions of one's own student days when although warned in classes that results of work moved slowly, yet how definite were one's own plans for the rapid practical application of theoretical instruction.

The student must feel that the staff nurse is interested in her. Being an infant in public health experience she will depend a great deal on the staff nurse, who is perhaps her first teacher in the practice of the special work she has chosen and the application of her as yet untried theories to those homes. As it is well known individuals must be studied; environment, social handicaps, poverty and all the other things met in daily contacts and teaching modified in relation to these obstacles. Very often one's whole plan for a given visit must be changed until a later and more favourable time in order to meet the immediate need. The staff nurse will serve her purpose in her responsibilities for her student through the careful application of her own experience in health teaching and the carrying out of the routine procedure of her organisation in the development of these various cases.

The plans of a staff nurse for the initiation and subsequent experience of the graduate student throughout the entire period of field work have a very important bearing on the continued experience in practice of this new public health nurse.

IV

Plans for Initiation and Subsequent Experience in School Health Work from the Standpoint of the Staff Nurse

By ELIZABETH PRICE,
Department of Public Health,
Toronto, Ont.

1. The staff nurse will be careful to stress the responsibility of the principal in all school matters.

2. *First Morning*: (1) Observation of morning routine: (a) Setting up Health Service Room; (b) Readmissions with explanations; (c) Exclusions—and forms; (d) Transfers in ———; (e) Dental appointments; (f) Conference with principal, teachers pupils and parents; (g) Filing of

work slips; (h) Making work slips or return reports for follow-up visits to homes—visits probably made later in the day with the student observing; (i) Classroom inspection—the student observing. There may or may not be a classroom talk.

Second Morning: (1) The student shares the morning routine; (2) Classroom inspection: two parallel lines of children—one to the nurse, one to the student—close enough for conference. A talk by the nurse followed by a conference with the teacher regarding pupils, with the student observing.

Third Morning: Same—with explanation of records. The nurse supervises the student's part of the work.

Fourth Morning: Classroom inspection done by the student with the nurse supervising; a health talk included. (Most students prefer small children who behave better with visitors. It would seem a good practice to use junior classes. The nurse supervises again in the second week. When there are two or more schools the student might be allowed to carry the smaller one, with the district superintendent supervising.)

3. The records should be fairly well covered by now since explanations were given daily as occasion arose on preceding days.

4. The preparation for complete physical examinations should be made with the student assisting. She should be allowed to carry on alone, from preparation to completion twice during the field work period.

5. Practice in arranging for psychiatric examination with taking of social history.

6. Practice in arranging for special classes, e.g., sight saving, forest school, open air, etc.

7. The student should be allowed (where nurse has one school only) to carry on one day alone in the second week. Problems may arise which can be explained when the nurse returns. Later the student may have this

practice as often as suits the individual case.

8. The school nurse should make clear Toronto's system for procuring glasses, orthopedic appliances, milk, clothing, etc., for school children; i.e., through the district nurse. She should give such a picture of the school work that the student, when she takes charge of a new school, will be able to modify the procedure to suit a given situation.

V

Plans for the Initiation and Subsequent Experience in the Child Health Centre from the Standpoint of the Staff Nurse

By GERTRUDE HUNTER,
Department of Public Health,
Toronto, Ont.

There are several plans which might be used for the initiation and experience of student nurses in child health centres, but the following seems to the writer the most feasible. As each student is usually with a Department of Public Health nurse five weeks, her time be apportioned in this way:

First Week: Devoted to weighing and general observation, which should enable her to obtain:

- (1) A general idea of the child health centre and the way it is set up; also of the work and duties of the child health centre nurses.

- (2) Type, appearance and condition of the children attending.
- (3) Attitude of the mothers.

Second Week: Spent in taking on new histories, which would entail:

- (1) Interviewing the mothers and writing information on histories.
- (2) Filling in weight cards.
- (3) Writing return reports.
- (4) Filling in letters to family physicians for the child health centre physician to sign.

Third Week: Devoted to assisting the physician:

- (1) In a general way.
- (2) Writing his orders, together with any helpful information on return reports for the district nurse.
- (3) Interpreting his orders to the mothers and instructing them regarding preparation of feedings.
- (4) Giving reference cards to hospital clinics.
- (5) Arranging for extra nourishment.
- (6) Referring to social agencies.

Fourth Week: Spent in conferences with mothers and in health teaching with regard to:

- (1) Regular breast feeding.
- (2) Manual expression.
- (3) Diet.
- (4) Immunisation, etc.

Fifth Week: Devoted to getting a general idea of the records which might prove particularly helpful if a student nurse were planning to work alone in a rural community.

It would seem advisable for the Department of Public Health nurse to review with the student nurse the teaching and experience she has had in the child health centre. This might be done at the completion of each child health centre or in the district office in conference with the superintendent.

VI

Plans for the Initiation and Subsequent Experience in Home Visiting re Communicable Diseases from the Standpoint of the Staff Nurse

By IRENE WEIRS,
Department of Public Health,
Toronto, Ont.

I. Conference with Student: Before starting into the home to visit there should be a general discussion with the student as to procedures and relationships, e.g., quarantine regulations pertaining to communicable disease in the district, the responsi-

bility of the public health nurse, emphasizing the fact that one of the first reasons for the nurses being in the district is the prevention and control of communicable disease.

Prevention—explaining the use of existing clinics, means of reference to these and a discussion of existing cases upon which the nurses are working in the district.

Control—explaining the objective in the home visit to a suspicious and a diagnosed case.

A general discussion is important; it helps the student to get the public health nurse's viewpoint and helps the staff nurse to get the student's viewpoint; it creates more intelligent interest in the work to be accomplished in the home.

II. *Observation Visits*: When possible each type of visit should be observed by the student: exclusions from school, emergency calls, discharges from and admissions to hospitals, and the following of contacts. She should observe co-operation with the family physician, the district medical officer and the Division of Quarantine. Plans should be made to demonstrate each step whenever possible, e.g., telephoning, discussion with the district medical officer or district superintendent. The student should observe a diagnosed case cared for by the public health nurse in the home and should realise the nurse's responsibility for teaching a reliable member of the household the care of the patient, and ways of preventing others from contracting the disease. Although the student knows how to nurse communicable disease, it must be realised there is much to learn about care in different homes, inadequate equipment in the homes, and in many cases the poor mentality of the one who is to care for the patients.

Perhaps communicable diseases are not at their height at the time of the

year visits are made by the university students, and if it is not possible to see work with her own nurse, the opportunity should be given to go with those nurses who have active cases as different districts offer varied types of experiences.

III. *Experience*: The subsequent experience of the student, following her initiation, should be as varied and full as is possible. She should be allowed to carry the full detail of the work with supervision. The student might carry some cases of tuberculosis (not all would be advisable). It would be ideal if she could carry an active case waiting admission to sanatorium, an active case cared for in the home, and the supervision of contacts.

The field of communicable disease does not always present experience as desired, but not many visits in the home are without an opportunity to teach prevention or control of the common cold.

The following varied points should be covered during the field work period: bag equipment and its use; technique of taking a temperature and caring for the thermometer; the relation of the need for teaching of general health rules in the home to the control of communicable disease: repeated and persistent urging of immunisation against diphtheria and smallpox; the need for persistent effort in dealing with skin conditions. The dress of the public health nurse at all times is also a point in the teaching.

Ideals: The university student comes to the field with an ideal of the part the public health nurse can play in control of communicable disease. In the difficulties met in making adjustment in the home due to poor equipment, etc., it is well to keep ideals constantly in mind, that the situation may be handled as well as is possible.

VII

Plans for the Initiation and Subsequent Experience in Home Visiting regarding Health Supervision from the Standpoint of a Staff Nurse

By GERTRUDE REID,

Public Health Nurse, New Toronto, Ont.

Criteria adopted for students in field work in a large centre cannot always be fully carried out in a smaller community, where there is only one nurse to plan and carry out every phase of the work. There are many demands on her time that are not made upon the staff nurse in a city. Moreover, it is not always possible to find suitable families to give the student supervised experience in home visiting. The people are so accustomed to having one nurse, that it would seem advisable for the student to merely observe in these cases and then go back alone and make her own contacts with the family. Such families must be selected especially for this, as some people are so strongly opposed to all public health work and are inclined to consider the appearance of any new person as undue interference. This might also apply were the student to make three visits to one home in so short a time, as it is seldom a nurse, working alone, visits that frequently. It would be apt to give a wrong impression and wrong impressions, like diseases, are very communicable in a small town.

It may be possible in some rural communities to fully meet the demands of the criteria but in others, the student's time is fairly well filled if she observes and takes part in all the public health nursing activities, that is, if the staff nurse presents her whole programme to the student.

VIII

Modification in the Small Health Centre or Rural Community from the Standpoint of the Supervisor

By ELEANOR SEELEY,
Supervisor, Public Health Nurses,
Department of Health, Kitchener, Ont.

Without in any way seeking to modify the adopted schedule for students, the writer finds it becomes modified or curtailed somewhat all round for the following reasons:

1. A highly intensive programme is covered in one month.

2. The greater part of, if not all the first week, must be spent in observation.

3. The students, after a year's academic work, are fagged and appear to be driving themselves. The trying spring weather aggravates this.

4. The demands and exigencies of the staff nurse's own work very often throw the general schedule out. Special activities and emergencies coming up—such as vaccinations which are done about this time, the pre-school examinations in June, etc.—all tend to interrupt a general programme.

5. The schools at this season are working at high pressure, and the staff nurse's inclination is to disturb classes as little as possible.

6. The students work more slowly than experienced nurses, and all their visits, interviews, inspections, etc., are prolonged, taking extra time.

7. Again, owing to the weather, many calls are made uselessly as housewives are often out or engaged in spring cleaning. If a visit is made the circumstances are not always propitious.

8. The work and visits on mental cases have been done indifferently well, because the writer did not know just what the student was expected to have in this line.

IX

Modification in the Small Health Centre or Rural Community from the Standpoint of the Local Public Health Nurse

By GEORGINA CLARK,
Public Health Nurse, Paris, Ont.

Although the writer has had the pleasure of having only one student, the Medical Officer of Health, the Board of Health, all the private physicians of the town, the principal of the schools and the teachers feel that it is quite an honour to have a student visit. The student, with the public health nurse, is made most welcome and a keen interest taken in her so that she may receive the required experience.

The school work may be carried on practically the same as in the city schools. Last year the teachers rather resented the time taken for short health talks but this year they are most enthusiastic, having seen some results.

Difficulties do arise, however, in some of the technicalities of home visits:

(1) The type of visit: Last year there were no communicable diseases in town, consequently that type of visit could not be included in the programme.

(2) The mental hygiene visits were quite negligible as this type was not thoroughly understood and the work being so recently organised no outstanding cases had arisen.

(3) One cannot dissociate social work and public health nursing

work when one is the only professional worker in the field, since everyone looks to the public health nurse for advice and help whether of a social nature or a public health one. Unfortunately a large percentage of these families resent the presence of a stranger, and as most of the prenatal visits made are included in this category, it makes it very difficult to give the student much experience in prenatal work.

(4) Visits made by the student alone are difficult. Possibly after the community becomes more accustomed to visitors these will be assigned more readily. As there has been a certain resentment toward the public health nurse visiting in homes it would seem impossible to risk allowing the student to visit alone in case future visiting were denied. If a student could have as much experience as possible in home visiting and some supervision of these visits, this problem would be greatly helped.

At the Child Welfare Conference there is no doctor in attendance. The student is able to put into practice all of her teaching as the majority of mothers are most interested in the welfare of their baby and most anxious to hear about anything that will be helpful. However, in conducting a conference alone the same problems arise as in home visiting alone. It does seem inadvisable to allow this at present.

The writer's opinion is that the Public Health Nursing Course is quite incomplete without some field work with the Provincial Department of Health.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section.

Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

Are There Too Many Nurses?

By JEAN DAVIDSON, Paris, Ont.

Nurses! nurses! everywhere, and many of them have the same refrain: "I haven't worked for many weeks," and more often, months.

In reading an article, written by Hazel Rawson Codes, much interesting information is given regarding the oversupply of nurses.

The private nursing field is the one which suffers most from overcrowding. True, many fine nurses enter the private duty field and stay in it because they love it, but often the private duty nurse feels discontented, ill adjusted and under-paid. This may be, because she has not had the proper education and technical training for any special branch in the profession.

There is a comparative lack of highly trained nurses for obstetrics, pediatrics and nervous diseases and not enough skilled in diet disease and contagious work.

Better positions are seeking applicants but while there is an abundance of less highly trained nurses, the trouble lies in the lack of educational requirements and facilities. There is a definite effort in the nursing profession to make a complete high school course a minimum requirement.

Dr. G. M. Weir, in the Report of the Survey of Nursing Education in Canada, has submitted some interesting conclusions on work and pay: The private duty nurse averaged 29.9 weeks' work a year, 14.3 weeks' idleness, ill 4.5 weeks and vacation 3.3 weeks; her median annual gross income was \$1,022.00. The public health nurse averaged 47.1 weeks' actual nursing duty, 4 weeks' vacation and .9 week's illness; her median annual gross income was \$1,575.00. The institutional nurse

averaged 46.3 weeks on actual duty, 4.2 weeks' vacation, .8 week's illness and .7 week's unemployment. Her median annual gross income was \$1,385.00.

The appeal of the nursing profession is never fundamentally money. It is that vital human quality which is always present in work on such intimate terms with human beings. A good nurse must be strong, deft, poised, tactful, patient, controlled, serene, not dull but sensitive in the best meaning of the word.

Also, she must be animated by intelligence as well as great human understanding. She must be neat, thorough, faithful and sense emergencies and possess the courage to act in them on her own initiative.

Nursing is gradually dovetailing with efforts to improve the health of the people. The aim of any nurse, institutional, public health or private duty, is to leave her patient knowing more about health than he did before he became ill.

There has been and is a great deal of dissatisfaction among private duty nurses, due to the uneven employment and a corresponding irritation in the public mind, of the costliness and sometimes the inadequacy of nursing service. Definite efforts are being made to raise the educational requirement and standardise training; also, plans for organisation of registries in touch with the community so that nurses will be supervised for better service.

From the standpoint of both nurses and public, there is merit in the hourly nursing plan whereby registries charge by the hour for a nurse's services but pay her a flat rate to assure her a dependable living wage.

News Notes

ALBERTA

CALGARY: The Alumnae Society of the Holy Cross Hospital in Calgary came into existence in May, 1931. The Holy Cross Hospital belongs to the Sisters of Charity, or, as they are sometimes called, The Grey Nuns of Montreal. These Sisters have training schools in Canada and in the United States, as well as orphanages, schools and homes for the aged. There are over a hundred graduates of the Calgary School scattered all over the world, even in the far North, where some of the Nuns who are also registered nurses are pioneers in remote and inaccessible places. It was through the efforts of Sister St. Jean de l'Eucharistie, who was the Superior of the Holy Cross Hospital for nine years, and those of Mrs. de Satge, who has been for many years in charge of the Records and is now Instructor of Nurses, that all these nurses were communicated with and an Alumnae Society organised. The inauguration of this society was marked by a reception and tea in the reception room at the Nurses Home, where the guests, over a hundred graduate and student nurses as well as their friends, were received by the Sisters and the officers of the Society. The aims of the Alumnae are: (1) To keep in touch with all graduates of the Holy Cross Hospital, Calgary; (2) To visit the sick nurses and provide them with flowers; (3) To provide indigent patients or their babies with clothing. There are fifty-five paid-up members at present, and the officers are: President, Mrs. L. de Satge; Vice-President, Miss A. Willison; Corresponding Secretary, Miss P. N. Gilbert; Recording Secretary, Miss E. Thom; Treasurer, Miss S. Craig; Honorary Members, Rev. Sister St. Jean de l'Eucharistie, Miss M. E. Brown.

LETHBRIDGE, ALTA.: The regular meeting of the Lethbridge Graduate Nurses' Association was held at St. Michael's General Hospital on January 11, 1932. The meeting was preceded by a delicious banquet served by the Sisters of St. Michael's. Approximately forty nurses were present. The speaker of the evening was Mr. A. E. Russell of the Metropolitan Life Insurance Company.

At the February meeting an election of officers was held. Officers for 1932 are as follows: President, Miss L. Parry; Vice-President, Miss M. Slater; Secretary, Miss B. Ford; Treasurer, Miss J. MacKenzie; Registrar, Miss A. Tilley; Conveners of Committees: Social, Miss McGowan; Programme, Miss B. Clark; Membership, Miss L. Watson; Sick Visiting, Mrs. P. M. Sauder; Local Council, Mrs. R. Wilson; Conveners of Sections, Private Duty, Miss L. Larson; Nursing Education, Miss H. Levenick. Regular meetings held on the second Monday of each month.

The March meeting was held at the home of Miss L. Watson, twenty nurses being present. Arrangements were made for the

annual dinner and bridge. Following the business meeting Dr. R. W. Lynn gave a very interesting talk on Birth Control. Miss Heather Jardine was appointed as the Lethbridge delegate to the A.A.R.N. Convention at Edmonton on March 22nd and 23rd.

On April 11th the Association held its annual dinner. Approximately forty nurses from Lethbridge and district were present. The catering was undertaken by the Women's Auxiliary of a local church. Following the dinner, Mr. T. Burnett, with his kaleidoscope, took the guests on a world tour, including the Holy Land, Egypt, the Orient, India and Honolulu.

On April 26th the Association entertained the Graduating Class of Galt Hospital at a delightful Spring Tea given at the home of Mrs. P. M. Sauder.

The regular monthly meeting in May was held at the home of Mrs. R. W. Lynn. The financial report showed a credit balance of \$73.76. The Registrar's report gave the names of three additional members. Miss H. Jardine, delegate to the A.A.R.N. Convention, gave a splendid report of the Provincial Meeting. The members found it most enlightening and many discussions followed. The next meeting was held at the Galt Hospital on June 13th.

GALT HOSPITAL, LETHBRIDGE: The graduation exercises were held at the Wesley Church, April 28th. Eight nurses received their medals and diplomas. Following the ceremony, the graduating class and their friends were entertained at a dance in the Masonic Hall, given by the Hospital Board.

MEDICINE HAT: The Graduation Exercises of the Medicine Hat Training School for Nurses were held at Fifth Avenue Church on June 2nd. The church was filled to capacity, and amid a profusion of beautiful flowers the graduates received their diplomas, which were presented by Miss Mary N. Murray, acting superintendent. Mayor Bullivant presented the special prizes, which were awarded to: Miss Ellen Ostlund, general proficiency; Miss Kathleen Bell, surgery; Miss Beatrice Harvey, obstetrics; Miss Violetta Neal, practical work. Mr. G. M. Blackstock addressed the graduating class and Dr. B. C. Armstrong administered the Nightingale Pledge. A musical programme was given by local artists.

The Medicine Hat Graduate Nurses Association was represented at the Biennial Convention in Saint John by Mrs. Mary Tobin.

The Association has suffered the loss of one of its most outstanding members in the death of Miss Edna Mabel Auger on May 2, 1932. The late Miss Auger was born in Chatham, Ont., and when seven years of age the family moved to Maple Creek, where she received her early schooling, going east to Ontario to

take her high school course. She returned to Medicine Hat in 1903 and, entering training in the General Hospital, graduated in 1906, then becoming operating room nurse on the staff of her alma mater. In 1910 she went to New York for post-graduate work. In that city she worked under Dr. Erdman at Dr. Bull's hospital until 1913, when she returned to Medicine Hat as assistant superintendent.

Commencing overseas service in 1915, Miss Auger served with the Canadian Army Medical Corps Nursing Service until she returned home late in the fall of 1919. A year later she organised a hospital at Grande Prairie, but came back in 1921 to take the position of lady superintendent of the Medicine Hat General Hospital, which position she held at the time of her death.

While overseas she won a high reputation of efficiency in her work, and for bravery in the face of danger she was awarded the Royal Red Cross medal. At home in more peaceful surroundings she enhanced that reputation by her efficient administration and devotion to duty while in charge of the hospital here.

The death of Miss Auger marks the passing of one who visualised her life work, prepared herself for it, following in the noble footsteps of Florence Nightingale, ever effusing the radiance and nobility of a life for others.

BRITISH COLUMBIA

Results of Examination for Registered Nurse's Certificate

An examination for Title and Certificate of Registered Nurse was held recently throughout the province of British Columbia with the following results:

154 wrote the examination.

142 passed.

4 passed with supplementals to write.

Standing order of merit:

First Class—80% and over:

Misses J. H. Collett, Royal Jubilee Hospital, Victoria; M. G. Prescott, Vancouver General Hospital; E. F. Crampton, St. Joseph's Hospital, Victoria; M. J. Birdick, St. Joseph's Hospital, Victoria; M. A. Clarke, Royal Jubilee Hospital, Victoria; Mrs. N. M. Dickinson, Royal Inland Hospital, Kamloops; A. M. Milnes, Vancouver General Hospital, Vancouver.

Second Class—65% to 80%:

Misses K. M. McDonald, R. W. MacGillivray, Sister Ignatia, (A. M. Field and H. B. Keeler—equal), H. G. Barron, D. E. Cann, (G. B. Harvey and C. C. Ford—equal), (I. J. Clark, M. Balderston and M. L. Dobbin—equal), M. Jaques, M. L. Mott, M. T. Hodgson, R. F. McKernan, (E. C. Miller and L. W. D. Haines—equal), (M. M. Wilson and M. I. Maddaford—equal), B. V. G. Ross, M. Campbell, (M. Leman, M. MacIvor and F. Willan—equal), M. E. Smith, E. Taylor, (A. E. Robertson, E. D. Greenlees—equal), F. I. Goward, D. M. Hall, M. M. Fletcher, L. M. Blomberg,

M. Laity, (E. E. Braund and W. R. Travis—equal), (M. C. Otterbine, H. E. Stephen and E. E. Rossiter—equal), (H. M. Bell and I. V. Hewer—equal), (I. Clare and F. Gillies—equal), (M. E. Smart, Sister M. Audrey, E. N. Wadelin and O. M. Gray—equal), M. D. Burtch, (K. E. Green and E. Pease—equal), L. M. Hughes, (H. McL. Mutrie, M. F. Clements and T. I. Kearns—equal), K. Hessey, (K. Moore and K. M. Stowe—equal), (E. C. Bragg and G. S. Christie—equal), (E. S. Dempsey and M. Woollett—equal), Mrs. G. M. Beech, (M. A. McIntyre and M. E. J. Spooner—equal), (J. M. Blake, J. McL. Nicholson and E. O. Mitchell—equal), E. F. Cunningham, E. K. Birley, (P. M. Bond, E. Collins, V. M. Neil, L. Lieman and B. O. Orr—equal), (M. A. Amos and M. C. Naylor—equal), (M. B. Cummings, M. R. Earle, L. T. Fagan and M. J. Field—equal), (R. J. Younge, E. L. Johnson—equal), (M. Gracey and D. M. Clarke—equal), M. L. Armand, (F. E. H. Whitaker, T. LaR. Baker—equal), (M. A. Burnes, E. Reid and P. E. Rockwell—equal), O. Foss, (E. M. Moody and Sister J. de la Passion—equal), (P. Riley and D. S. Grant—equal), (M. A. Ennis, M. E. Gibbons and M. E. Rasmussen—equal).

Passed—60% to 65%:

Misses (K. V. Johnston, A. G. C. Hallstrom, Mrs. O. Purvis, E. E. Short and C. Reid—equal), (G. M. Smith and J. T. Stelmack—equal), (Chelta Reid, G. M. Higgs and E. A. Postill—equal), (M. J. DuMont, M. G. Buckan, D. E. Lovering and M. I. Hoggan—equal), (H. M. Flumerfelt and A. M. Gee—equal), Sister M. Faustina, (I. G. Facey, A. J. Lathrop and E. E. MacKenzie—equal), I. M. Matheson, M. M. Foster, D. L. Lee, (S. I. LeQueia and E. V. Stenner—equal), (E. D. Doe, L. C. Wilson and L. E. Tripp—equal), (P. O'Sullivan and J. E. Fontana—equal), B. D. W. McGillivray, J. L. J. Bourke, S. I. Maki, (L. Crandlemire and M. E. Falding—equal), V. M. Darney.

Passed in supplemental:

Miss E. V. Johnston.

Passed with supplementals to write:

Misses L. I. Buckmaster, H. K. Beckett, (N. E. Foster and I. M. Morgan—equal).

MANITOBA

BRANDON: The graduation exercises of the General Hospital were held on May 24th in St. Paul's United Church, when twenty-two nurses received their diplomas and pins from Robert Darrach, chairman of the Board, and Miss C. McLeod, Superintendent of the Training School. Dr. J. S. Matheson presented the medals—the Gold Medal to Miss Edith Duncan, the Silver Medal to Miss Ada Stanley, Bronze Medal to Miss Jean Meyers, Prize for General Proficiency to Miss Elizabeth Flett, and a prize for Dietetics to Lucy Lacey. In the intermediate year, Dr.

Bigelow's prize for surgery was won by Betty Birks, who also received the prize for highest standing in her year. Dr. Peter's prize was awarded to Gladys Slimons, and Dr. Sharpe's prize for paediatrics to Agnes McMillan. In the junior year Marjorie Jackson received the prize for General Proficiency awarded by Dr. Purdy Griswald, and Miss Brigham won Dr. Elliott's prize for highest standing in first year. Musical numbers were contributed by Miss Ruth Morgan and Dr. E. S. Bolton. A reception was held in the Nurses' Home, where Miss McLeod, Robert Darrach, and members of the graduating class received their friends.

NEW BRUNSWICK

The Saint John Chapter of the Registered Nurses Association held its closing meeting of the season in the Nurses Home of the Saint John General Hospital on May 16th. Miss E. J. Mitchell, the president, was in the chair. When the coming convention was spoken of, it was estimated there would be between two hundred and fifty to three hundred nurses assembled at the Biennial Meeting of the Canadian Nurses Association. Outstanding leaders in the profession will take part in the programme.

SAINT JOHN GENERAL HOSPITAL, SAINT JOHN: Mrs. G. L. Dunlop was elected president of the Alumnae Association at the meeting held in the Nurses Home on May 9th. Others elected were as follows: First Vice-President, Miss Ethel Henderson; Second Vice-President, Mrs. F. M. McKelvey; Treasurer, Miss K. Holt; Secretary, Miss Jane Thorne; additional members, Mrs. J. H. Vaughan, Mrs. H. H. McLellan and Mrs. A. C. Clinch. Gratifying reports of the work of last year were presented.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in June, 1932, were 973, forty-one more than in May, 1932.

APPOINTMENTS

Miss Grace Chapman has been transferred to the Mountain Hospital, Hamilton. Miss Mary Langford has been transferred from the Mountain Hospital to the General Hospital, Hamilton.

DISTRICT 1

VICTORIA HOSPITAL, LONDON: The annual picnic of the Alumnae Association was held recently at Springbrook Park. Ninety-eight members with their friends and children were given a most enjoyable outing. A dainty lunch was served by the refreshment committee, and in the evening a novel programme of games and races was introduced. Miss M. Jones, the president, made an interesting announcement regarding a golf tournament to be held at the Fairmont Golf Course.

DISTRICT 2

GENERAL HOSPITAL, GUELPH: It is very much regretted that Miss Bliss has resigned as superintendent of the General Hospital and left on May 14th to go to her home at Perth, Ont. The Alumnae Association

entertained at afternoon tea and presented Miss Bliss with a beautiful silver tray. Presentations were also made by the staff members of the Hospital, student nurses and Medical Association.

Miss Hardey left June 1st for Toronto Western Hospital, where she will take a three months' course in operating room technique.

Miss Dennis and Miss Fennel recently received their diplomas in Public Health Administration at the graduating exercises of Western University, London.

Miss Watson, who has been very ill, has gone to her home in Fergus, Ont., much improved.

HOMEWOOD SANATORIUM, GUELPH: The graduating exercises of the 1932 Class were held on May 31, 1932, at the Sanatorium.

ST. JOSEPH'S HOSPITAL, GUELPH: The graduating class of 1932 were entertained at dinner by the Alumnae Association on May 31st at the Edgehill Tea Room. The graduating exercises were held on June 2nd at the Collegiate Auditorium.

KITCHENER-WATERLOO HOSPITAL, KITCHENER: National Hospital Day, May 12th, was observed at the Kitchener-Waterloo Hospital, when the building was thrown open for inspection.

The Alumnae Association entertained the 1932 graduates at a banquet on May 12th. The graduation exercises of the Hospital were held on May 19th at the Collegiate Auditorium.

On May 26th the staff and pupil nurses of the Hospital and graduate nurse friends of Miss Mary Ward, assistant superintendent, showered her with gifts in view of her approaching marriage.

NORFOLK COUNTY HOSPITAL, SIMCOE: Miss H. Booth has been vacationing for the past week in Clinton, Ont. Miss P. Pringle has spent a week at her home in Owen Sound.

GENERAL HOSPITAL, BRANTFORD: The graduating exercises of the 1932 Class were held on June 3rd at the Brantford Collegiate Institute, when twenty-five young women received their pins and diplomas. Scholarships were won by: Misses Clara Biffin, Jean Zurbrigg, Lena L. VanEvery; Intermediate scholarship, Miss Jean Baird; and Junior Year prize, Mrs. Mildred Gehman. Mr. Norman Somerville, K.C., addressed the graduates. A reception was held immediately following the exercises, when the guests were received by Miss E. M. McKee and Miss Jessie M. Wilson. In the evening Miss McKee entertained at a dance in honour of the graduates at the Brantford Golf and Country Club.

The graduating class of 1932 were guests of honour at the alumnae reunion, which took the form of a dinner dance at the Brantford Golf and Country Club.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Members of the Alumnae Association entertained at tea in honour of the 1932 graduating class. The guests were received by Miss E. C. Rayside, Superintendent of Nurses, Miss

Clark, Superintendent of Nurses of the Mountain Hospital, and Miss Buchanan, president of the Alumnae. Presiding at the tea table were: Mrs. B. McBride, Mrs. R. Hess, Miss May Hipwell, Mrs. J. B. Lannin and Mrs. James Roberts.

DISTRICT 5

TORONTO: A general meeting of District No. 5, R.N.A.O., was held at the Royal York Hotel on May 21, 1932. During the afternoon session reports from various committees were received and abstracts from the Survey of Nursing Education in Canada were discussed by the Public Health and Private Duty sections. A dinner meeting was held in the roof garden, when about 120 members were present. The speakers were Miss Jean E. Browne and Dr. E. M. Best. Miss Browne outlined briefly Dr. Weir's report of the Survey. Dr. Best spoke of the qualifications of the individual that society is looking for today. Professional education was the prevailing spirit of the evening.

WESTERN HOSPITAL, TORONTO: On May 10, 1932, in the Nurses Residence, the members of the Alumnae Association were honoured by the presence of Miss Florence Emory, President of the C.N.A. A brilliant address on the history of the C.N.A. and the importance of membership in that organisation was given by Miss Emory. The meeting closed with a social hour.

On April 27th, 1932, the Alumnae Association entertained the graduating class with a banquet given in the roof garden of the Royal York Hotel. Covers were laid for one hundred members with thirty-four of the graduating class. Speeches, toasts and a valedictory contributed brightness to the affair. The toast to the class was proposed by Miss Mary Bird (1927); Miss Kathleen MacMillan (1929) proposed the toast to our alma mater, which was responded to by Miss Ellis, Honorary President. Miss Ludlow (1931) proposed a toast to the absent members, which was responded to by a letter from Miss Frances Wiltsie (1930). The entertainment was concluded by dancing and bridge.

The graduating exercises of the Toronto Western Hospital took place at Convocation Hall of the Toronto University on June 2, 1932. Rev. Canon Cody, D.D., LL.D., gave the invocation and address. Mrs. Alex. Fasken presented the diplomas and pins. A number of prizes and a scholarship were awarded several members of the graduating class. The H. A. Beatty Scholarship, McGill University, Montreal, for one year's post-graduate work in Teaching and Administration was presented to Miss Kathleen MacMillan (1929). A prize of twenty-five dollars from the Alumnae Association was presented to Miss Pearl Shore (1933) for Proficiency in Bed-side Nursing. Following the exercises a reception was held in Hart House.

Miss Ruth Kenney (1920), of Miami, Florida, visited the hospital and class-mates recently.

DISTRICT 5

TORONTO GENERAL HOSPITAL, TORONTO: Miss Joliffe (1931) has left for Saskatchewan to do district nursing. Miss Doris Williams (1930) has gone to North Dakota, and Miss Eunice Bebres (1931) to Seattle, to do district nursing.

A delightful shower for Miss Frances Hannafor (1923) was given by Miss Meta Gretzner, at which about twenty members of the 1923 class and others were present.

COLLINGWOOD: The annual meeting of the Nurses Alumnae of the General and Marine Hospital was held in the Board Room of the Hospital on May 27th. After the business had been fully dispensed with the secretary reported seven regular meetings held during the year, with an average attendance of ten members. A number of social functions were held during the year. Also several new articles added to the room which the Alumnae is furnishing in the Hospital. The Treasurer reported a membership of thirty-three in good standing, with four in arrears. Officers elected for the ensuing year are as follows: Honorary President, Mrs. Price; President, Miss K. Hanley; First Vice-President, Miss L. Ludlow; Second Vice-President, Miss B. McQueen; Secretary, Miss F. Pearen; Treasurer, Mrs. J. McAllister; Social Committee, Mrs. F. Watts, Misses Robinson and Cooper; Telephone Committee, Misses Robinson, Brown and Faulkner.

OSHAWA: The graduation exercises of the General Hospital Training School for Nurses were held in the Collegiate Auditorium on June 7th. Ten candidates received their diplomas and medals.

DISTRICT 6

ONTARIO HOSPITAL, WHITBY: The Alumnae Association honoured the 1932 graduating class with a dinner and dance. This was held on May 16th at the Falcon Inn, Kingston Highway. The speakers of the evening were Miss R. G. Bryon, Honorary President of the Association; Miss P. Sharpe, President; Miss E. Porter, representative to The Canadian Nurse. Miss L. Fair, Miss L. Scholtz and Miss M. Coe spoke on behalf of the graduating class. Mrs. Merson, Instructor at the Whitby Institution, spoke briefly on some aspects of nursing life. Everyone spent a very pleasant evening.

DISTRICT 8

PEMBROKE: The spring meeting of District No. 8 was held in Pembroke on May 21, 1932, with about one hundred nurses from Ottawa and vicinity present. During the luncheon, held in the school room of Calvin United Church, the speakers were Dr. Sparling, Medical Health Officer of Pembroke; Mr. McCormick, of the Board of Governors of the Cottage Hospital; and Rev. Allen, of Calvin United Church. At the afternoon session Dr. C. M. Purcell gave an interesting address on "Teeth and Health". This was followed by a demonstration of First Aid by a St. John's Ambulance team from Ottawa. The afternoon was brought to a close by a

tour of the hospitals, followed by a delightful tea at Pettawawa, which was sponsored by the nurses of Pembroke. The members of District No. 8 feel they owe a debt of gratitude to Miss Hodgins, Superintendent of the Cottage Hospital, and to Sister Mary Bridget of the General Hospital; also to the Board of Governors of both hospitals for making possible a day so filled with pleasurable interest.

LADY STANLEY INSTITUTE, OTTAWA: The annual meeting of the Alumnae Association was held at the home of Mrs. G. O. Skuce on May 13th. The following officers were elected for the coming year: Hon. President, Miss Mary Catton; Hon. Vice-President, Miss Florence Potts; President, Miss Jean Blyth; Vice-President, Miss M. McNeice; Secretary, Mrs. L. Morton; Treasurer, Miss Mary Slinn; Directors, Misses McColl, McQuade, Bedford and Mrs. Elmitt; Press Representatives, Misses E. Allen and A. Ebbs; Flower Convener, Mrs. V. Boles.

QUEBEC

GENERAL HOSPITAL, MONTREAL: The following members of The Montreal General Hospital Alumnae Association were among those who received certificates from McGill School for Graduate Nurses on Convocation Day, May 25, 1932: Miss Kate L. Annesley (1928) received certificate for Teaching in Schools of Nursing; Misses Edna L. Church, Ethel B. Cook (both 1928), and Miss Louise Stedham (1930), all received certificates for Public Health Nursing.

The Alumnae Association arranged an informal reception in the School for Nurses in honour of the graduating class 1932. The guests, who numbered approximately 300, were received by the President, Miss E. Frances Upton, and Miss Mabel K. Holt, Lady Superintendent, and included, besides the class, all those who had assisted with the education of the Class during the past three years. The event was a most enjoyable one, resembling a large family reunion.

Sixty nurses received their medals and diplomas on June 8, 1932: Misses V. B. Almond, M. E. Bernard, G. E. Blakney, A. G. Brewer, E. E. Campbell, E. M. Coffin, D. L. Cosman, A. F. Coughtry, N. F. Crandell, E. I. Denman, J. P. Dustin, F. S. Evans, I. A. Frizzell, M. E. Fulton, I. F. Gerneroy, G. M. Goobie, M. C. Hamilton, A. J. Harvey, M. K. Henstridge, G. P. Hjertholm, J. E. King, H. P. Lockhart, E. R. Marshall, E. M. Maynes, N. N. Meighen, F. E. Melkman, M. de S. Murphy, I. N. MacIver, F. M. MacKinnon, K. C. McLeod, V. M. MacRae, D. M. McCracken, K. S. Osmond, D. R. Petrie, A. B. Rodger, M. A. Shannon, H. K. Shaw, C. B. Spriggers, E. M. Sykes, M. K. Wilbur, C. H. Wilson, D. E. Wostenholme; Final Standing 80% and over for theoretical subjects in the Nursing curriculum: Misses C. L. Anderson, M. A. Baxter, E. M. Bradford, N. T. Christie, M. G. Copland, E. Donald, E. M. Fisk,

C. H. Foster, C. Michaels, Y. Michaud, E. W. Moffat, A. M. Murphy, M. E. McKiel, O. M. Roe, M. E. Small, B. E. Steele, B. C. Underhill, E. H. Watson.

Prizes presented by the Board of Management of the Hospital for General Proficiency were awarded to Miss F. M. MacKinnon and Miss B. E. Steele, and the Mildred Hope Forbes Scholarships, awarded for the highest aggregate marks during the three years, were received by Misses N. T. Christie and C. L. Anderson.

Miss Norena S. MacKenzie (1926), certificate for Teaching in Schools of Nursing, McGill School for Graduate Nurses (1928), has been awarded a special scholarship from the Mildred Hope Forbes Memorial Fund. Miss MacKenzie expects to leave for England on July 2nd, and will follow a post-graduate course of study and experience which has been arranged by Miss Parsons, Director of Education, College of Nursing, London, England, and will cover a period of several months. Miss MacKenzie, who is a native of London, Ontario, has been a member of the teaching staff of the Montreal General Hospital, since 1923 previous to which she did Red Cross Outpost Duty in Ontario for one year.

Among those who left Montreal to attend the Biennial Meeting of the C.N.A. in Saint John are: Misses Jennie Webster, M. K. Holt, Agnes Jamieson, C. M. Watling, Eleanor Handcock, Beatrice Hadrill, and E. Frances Upton.

EASTERN HOSPITAL, MONTREAL: The programme committee were fortunate in procuring Dr. E. C. Menzies to address the Alumnae at the regular meeting in May, which was held in the Nurses Home. Dr. Menzies spoke on Nervous Diseases in a most interesting manner. The usual social half-hour was spent afterwards. Mrs. H. F. McLean (Irene Robertson, 1916), of Merrickville, Ont., left early in April to spend some time travelling in Europe. Miss Lillian Brand, accompanied by friends, sailed from Montreal for France on May 7th. Miss Jean Whimbey has returned to Montreal from Bermuda, where she spent the winter months.

HOMOEOPATHIC HOSPITAL, MONTREAL: Mrs. H. Pollock has returned to Montreal from Bermuda, where she spent a short vacation. Miss M. E. Anderson (1931) has been appointed to the night staff in charge of the Case Room. Sympathy is extended to Miss D. W. Miller in the loss of her father; also to Mrs. C. Ciceri (Ruth Mowry, 1918) and Mrs. T. Costigan (Esther Mowry, 1930) in the loss of their sister Mildred, (1926).

THE CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The annual dinner given to the graduating class by the Alumnae Association was held at the Queens Hotel on May 9th. Miss Marion Lindeburgh of McGill University gave a most interesting talk. Miss I. Young, soloist, rendered two delightful selections.

The graduating exercises were held in the hospital on May 10th. Dr. Goldbloom gave

an inspiring address to the class. Mrs. Gordon MacDougall presented the pins and diplomas. Miss A. S. Kinder received at a most enjoyable dance the same evening in honour of the graduates.

Miss A. S. Kinder and Miss E. Hillyard attended the Biennial Meeting of the Canadian Nurses Association held in Saint John, N.B.

Members of the Alumnae wish to join in offering congratulations to Miss M. Flander (1928), who has just completed a most successful year at the school for Graduate Nurses, McGill University. Miss Flander graduated with honours and was presented with the Lieutenant-Governor's Silver Medal.

Miss R. Miller (1928) has just completed a successful year at the School for Graduate Nurses, McGill University.

Miss B. Goobie, St. Johns, Newfoundland, is spending the summer in Montreal.

Miss J. Cochrane, of the O.R. staff, is away on vacation.

SASKATCHEWAN

THE CITY HOSPITAL, SASKATOON: The graduation exercises of the School of Nursing were held in Third Avenue United Church on May 12th. Miss E. Paloway received the general proficiency prize; Miss L. M. Thompson the gold medal for the highest standing in the senior division; and Miss J. Williamson the gold medal for the highest standing in the junior division. The S.C.H. Alumnae entertained the 1932 graduating class at a banquet in the Hudson Bay Dining Room on May 15th. Nurses representing many classes were present. Grace was said by Mrs. Miscampbell the first graduate of the school. The toast to the King was given by Mrs. Pendleton; The School, Miss E. Amas, responded to by Miss Watson; The Graduating Class, Mrs. Pulley, responded to by Miss Kettles. About one hundred nurses from the City Hospital attended service in Knox Church on Sunday night; Rev. J. A. MacKenzie gave the baccalaureate address to the graduating class. Over two hundred nurses in uniform attended the Florence Nightingale service in Third Avenue United Church on May 9th. The new wing of the City Hospital was opened on May 12th. The S.C.H. Alumnae has furnished three rest rooms, and the Soldiers' ward has been furnished by the I.O.D.E. chapters.

NATIONAL HOSPITAL DAY AT HOTEL DIEU HOSPITAL Chatham, N.B.

The Weatherman broke all records on May 12 of this year (1932). Following a week of sunshine, the day dawned warm and balmy, though somewhat cloudy. As the hour of noon approached, the sun broke through the mists, and we knew that the afternoon would be a pleasant one. This was a unique pleasure, when we recall that in former years the weather on this day has been anything but pleasant.

Two o'clock in the afternoon, the hour marked for the opening of hospital doors to the public, saw streams of visitors wending their way up the hill, to see, probably for the tenth time, since the inauguration of this Hospital Publicity Day, the institution which they have learned to recognise as the best friend in time of greatest need. Young and old passed gaily through the halls, visiting the different departments, and meeting perhaps, some familiar faces among the nursing staff, some who had cheered them through the lonely days of illness and suffering, in one or other of these departments.

Hospital Day means a day of teaching as well as of pleasure, and as the many visitors passed along the corridors, they were confronted by signs and signals at every turn, each in its own way pointing out the road to better health. On the third floor, the little ones were greatly interested in two tiny houses, which appealingly invited them. The Health House was built with all the food-stuffs that go to make up the strong and sturdy boy or girl. The Unhealthy House, though presenting attractive colours and tempting sweetmeats, was nevertheless condemned as a menace to the health of growing children.

On the second floor a class of little boys and girls, under the direction of two graduate nurses, demonstrated to an eager and admiring audience the first-aid lessons which are being taught in the class-rooms of the present-day schools.

The first floor was alive with a very busy group, for there the ladies of the Hospital Aid served dainty and attractive lunches to the visitors of the hour.

The very dainty and useful contribution to the nursery, on display, by the members of the I.O.D.E. needs no comment, for all visitors to the institution are fully aware of the fact, that the nursery and its tiny occupants are kept always in tip-top shape by these wonderful providers.

The Well-Baby Clinic brought to the hospital a number of little people who were gladly welcomed by the nursing staff, as Hotel Dieu Hospital babies, whose continued good health is a source of much pleasure to those who were the first to welcome them to the sunshine and gladness of old Mother Earth.

But the day with all of nature's brightness and warmth and good cheer would not have been half so attractive and pleasure provoking had it not been for the wonderful music supplied by the members of the Newcastle Band, who were among the first to reach the hospital entrance at 2 p.m. At frequent intervals during the afternoon the breezes carried soft melodies of the orchestra to the most remote parts of the extensive grounds.

One attractive feature of the different departments on this day was the display

of the many rare and beautiful potted plants in full bloom. This was due to the generosity of Mr. R. A. Snowball, who sent these beauties of nature to grace the occasion.

The school children were not left out of hospital celebrations. Miss Sophie McDonald, Reg.N., gave a pleasing and instructive lecture to the pupils of the higher grades, on "Communicable Diseases," showing how even they can help to combat these enemies of the human race. The younger children had their share of hospital instruction by listening to the reading of helpful little stories pointing out the rules of the Health Game.

A special feast had been reserved for all the pupils of the classes through the courtesy of the Marven Biscuit Company, who donated a generous supply of toothsome dainties on the request of the hospital superintendent.

When the gift baskets have been returned Hotel Dieu will welcome another occasion of thanking the public for their continued and generous aid in caring for the suffering.

Six o'clock closed National Hospital Day celebrations, when upwards of four hundred visitors returned to their homes, well satisfied with all the pleasures that the day had offered.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

CRAWFORD—On April 11, 1932, at Wingham, Ont., to Mr. and Mrs. Harley Crawford (Bernice Brown, Toronto General Hospital, 1930), a daughter.

COO—Recently, at Sudbury, Ont., to Mr. and Mrs. Cecil Coo (Madeline Dudley, Toronto General Hospital, 1923), a son.

HAMBLY—On May 9, 1932, at Montreal, Que., to Mr. and Mrs. Frank T. Hambly (Edith Black, Western Hospital, Montreal, 1925), a son.

HARRIS—On May 6, 1932, at Ottawa, Ont., to Mr. and Mrs. Fred Harris (Ruth Duquette, Ottawa Civic Hospital, 1929), a daughter.

HILLIKER—On April 29, 1932, at Toronto, Ont., to Dr. and Mrs. Hilliker (Kathleen Keyes Toronto General Hospital, 1920), a daughter.

IRVING—On April 11, 1932, at West Shefford, Que., to Mr. and Mrs. Lawrence Irving (Alida Thompson, 1925), a daughter, Margaret Patricia.

JOHNSTON—On April 25, 1932, at Ottawa, Ont., to Mr. and Mrs. John Dewey Johnston (Eva L. Thomson, Winnipeg General Hospital, 1923), a son, John Donald.

MCCONNELL—On May 26, 1932, at Toronto, Ont., to Mr. and Mrs. McConnell (Clara Wheatley, Toronto General Hospital, 1919), twin daughters.

McWILLIAMS—On February 26, 1932, to Mr. and Mrs. McWilliams (Freda Conley, Brandon General Hospital, 1926), a son.

PEARSON—Recently, at Brandon, Man., to Mr. and Mrs. Pearson (Christina Junek, Brandon General Hospital, 1930), a daughter.

ROWLEY—On April 20, 1932, at Montreal, Que., to Mr. and Mrs. R. B. Rowley (Frances Armitage, Western Hospital, Montreal, 1921), a son.

UREN—On May 31, 1932, at Toronto, Ont., to Dr. and Mrs. Leslie Uren (Mildred McGuffin, Toronto General Hospital, 1926), a daughter.

WILSON—On April 23, 1932, at Toronto, Ont., to Dr. and Mrs. Roy Wilson (Maud, R. Webb, Toronto General Hospital, 1914), a son.

WILSON—On May 3, 1932, at Ottawa, Ont., to Mr. and Mrs. Ernest Wilson (Audrey Cheney, Ottawa Civic Hospital, 1930), a daughter.

WOODS—On May 19, 1932, at Ottawa, Ont., to Mr. and Mrs. John E. Woods (Luella McEwan, Lady Stanley Institute), a son.

YEIGH—On May 20, 1932, at Toronto, Ont., to Mr. and Mrs. Yeigh (Margaret Pelton, Toronto General Hospital, 1929), a son.

MARRIAGES

GARRETT-WILSON—On April 20, 1932, at Toronto, Ont., Lillian Wilson (Toronto General Hospital, 1928) to Dr. Douglas Rogden Garrett, of Weston, Ont.

HIRD-ARMSTRONG—On May 23, 1932, at Brantford, Ont., Marjorie Ellen Armstrong (Brantford General Hospital, 1931) to Albert E. Hird. Residing in Brantford Township, Ont.

LUCAS-TAYLOR—Recently, at Minnedosa, Man., Helen Taylor (Brandon General Hospital, 1930) to E. J. Lucas.

MYLREA-DENYES—On February 20, 1932, Freda Denyes (Toronto General Hospital, 1920) to James Mylrae, of Toronto, Ont.

TROTTER-BRIGGS—Recently, Norma Briggs (Brandon General Hospital, 1930) to Dr. Harold Trotter. Residing in the Flin Flon, Man.

DEATHS

MOWRY—On May 14, 1932, at Montreal, Que., Mildred Mowry (Homoeopathic Hospital, Montreal, 1926).

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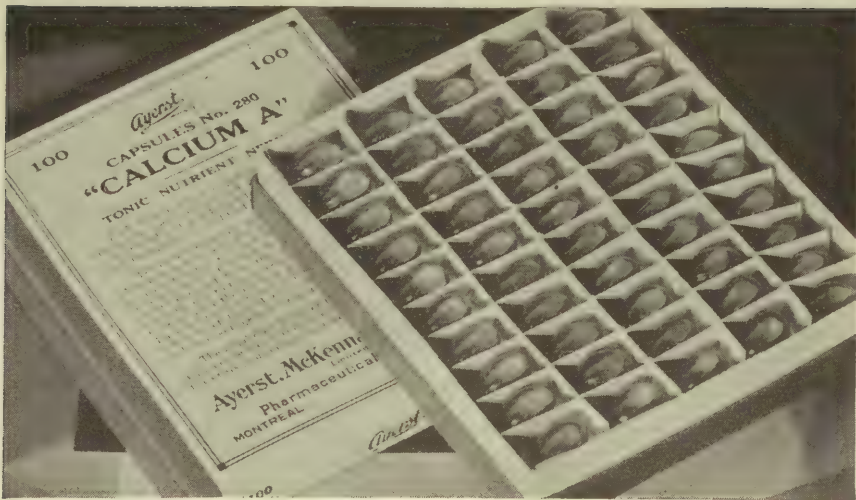
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The Biennial Meeting

All those who journeyed to "down by the sea" for the recent Sixteenth General Meeting of the Canadian Nurses Association participated in the most representative national gathering of nurses ever held in Canada. This was due to:

A registration approximating 500; an average attendance of 320, or more, at each session; the open meetings on Tuesday and Friday evenings were held in a public hall which was filled to capacity on both evenings. Four guest speakers on the programme for general sessions—all were present. Five Past Presidents in attendance. Sixty-four per cent. of the Executive Committee and eight of nine Provincial Presidents present, and Newfoundland represented. Conveners of committees (16), except three, gave reports in person. The Chairman and nurse members of the Joint Study Committee were present. Three objectives for 1930-1932 achieved: (1) Membership increased (nine per cent.); (2) successful termination of the Survey of Nursing Education in Canada; (3) decision to appoint a full-time Editor for *The Canadian Nurse*—although the C.N.A. has owned and published the Journal for sixteen years, the duties entailed have received part-time attention only by a nurse member.

Excellent arrangements were made by the New Brunswick Association of Registered Nurses, with courteous consideration from the entire staff at the Admiral Beatty Hotel.

The President officiated in a most admirable manner and was sustained by an active Executive Committee, keenly alert delegates and an interested "house" at each session, with all present participating according to approved parliamentary procedure.

The citizens of Saint John ably assisted the N.B.A.R.N. in extending hospitality—this consisted from the messages of welcome in the windows

of many business places to varied social entertainment of true Loyalist type. Outstanding was the boat trip on the Saint John River, with a beach supper at a private summer home. The N.B.A.R.N. was hostess on this occasion.

The open meeting on Tuesday evening held in St. David's Hall brought together over eight hundred nurses and their friends to hear the messages of welcome and the masterly address by the Honorable Vincent Massey. This address was printed during convention week and copies made available for distribution.

The evening of June 22nd, with the banquet, will be treasured in memory. More than 320 participated in this function, amid attractively arranged tables with their many twinkling pink and green candles and profusion of beautiful flowers. The dinner address by Professor Roy Fraser aroused many and varied emotions—there is no doubt that the speaker has a most intimate knowledge and appreciation of the nurse's life. Professor Fraser's address, as well as those of Professor Clarke and Dr. Stewart Cameron, appears in this issue of the Journal.

On Friday evening the session was held in St. David's Hall. The excellent addresses by Professor Clarke and Dr. Stewart Cameron were received with attentive interest and much applause. One sensed that Professor Clarke regards the education of the nurse most important in the educational scheme in Canada.

While large numbers were aware that the Joint Study Committee of Nursing in Canada was presided over by Dr. Stewart Cameron, probably few realised the sincerity and depth of Dr. Cameron's interest in the problems and difficulties confronting nurses and nursing. His presence for several days at the recent meeting and especially his address on Friday

evening let all Canadian nurses know that they have a champion in Dr. Cameron. May he find it possible to retain his connection with the National Joint Study Committee.

The members in general session on Tuesday afternoon honoured the memory of Miss Edna Auger by a two-minute silence. As Chairman of the Nursing Education Section, Alberta Association of Registered Nurses, she was a member of the Executive Committee, C.N.A., and had planned to be in Saint John. An active member in the interests of nursing education, Miss Auger's death is a loss to the profession, more especially in Alberta, where she served for over twenty years.

A pleasing feature of the session on Friday afternoon occurred when the President appropriately expressed the gratitude of the C.N.A. to the nurse members of the National Joint Study Committee for their distinguished contribution to the Survey of Nursing Education in Canada. These members, Miss Jean Gunn, Miss E. Kathleen Russell and Miss Jean Browne, were each presented with a small silver tray, suitably engraved; they have served on the Joint Study Committee since it was formed in 1927, and have been asked to continue on the Committee. Their consent is anticipated.

The Saint John meeting was the most momentous in the history of the C.N.A. It may be that some who attended were disappointed in that discussion of the Survey Report resulted in the formulation of general policies rather than the adoption of defined action on which the provincial associations can proceed. The former procedure is in keeping with the function and purpose of the national organisation. The study and application of the findings and recommendations of the Survey Report must be left to the Provincial Associations and Joint Study Committees to be made effective according to the conditions and needs of each province.

It was a very real pleasure to have Matron-in-Chief Margaret Macdonald

present, and joyous was the re-union of fifty or more former nursing sisters with their dearly loved Chief.

Messages of welcome and best wishes accompanied by baskets of flowers were received from numerous organisations. Among these were: The New Brunswick Association of Registered Nurses and the Local Council of Women. Greetings were sent by the Graduate Nurses Association of British Columbia, the Canadian Medical Association and the National Council of Women.

Formal resolutions of thanks have been sent to all those who assisted in making the recent meeting an epoch in C.N.A. gatherings. The Association is most grateful to all these, but words of thanks are most inadequate in expressing gratitude to Miss McMaster, President N.B.A.R.N., and to Miss Murdoch and the members of her Committee on Arrangements. The quiet, efficient way in which their plans were put into effect permitted the satisfactory consummation of a remarkably heavy programme. The presentation of a beautiful bouquet of roses from the N.B.A.R.N. to the President, Miss Emory, shortly before adjournment on Saturday morning was a final act of courtesy in a week which had been filled with evidence of New Brunswick nurses' ability to be ideal hostesses.

The Registered Nurses Association of Ontario extended an invitation to the C.N.A. for the Seventeenth General Meeting to be held in Toronto in 1934. That gathering has historical significance as the Canadian Nurses Association will have reached its twenty-fifth year. The invitation from the nurses of Ontario is supported by cordial letters from the Premier of Ontario, the Mayor of Toronto, the President of the Board of Trade of Toronto, and several Service Clubs. The invitation was accepted with applause—plans, in part, are already outlined for the Toronto meeting. Nurses will do well to determine now that they shall take part in the Silver Jubilee celebration of the Canadian Nurses Association.

The Medical and Nursing Professions and the Survey Report

By G. STEWART CAMERON, M.D., F.R.C.S.(C), Chairman, Joint Study Committee,
Survey of Nursing Education in Canada

In the world in which we live, change is the order. It must be progress or retrogression. The human race—notwithstanding many pessimists to the contrary—is steadily moving forward. Measured in days or years, little or no advance is seen, but measured in centuries it is noticeable to all. The evolution of the human race from the primitive life of ancient times is evidence of this. In the process of development, emphasis has been increasingly placed upon the training of the mind. Whatever, therefore, may be the particular calling or profession, individual success can only be attained by having the mind thoroughly trained and equipped. Such training is in line with the principles of all progress. The successful man or woman must learn to think, and to think logically. He must be made familiar with the varied avenues of intellectual activity—science, art, literature—and the standard of excellence in each, so as to determine his own course according to his special aptitudes. At the same time, he must keep abreast of the movements of his own day in order to see his work in its proper perspective. Education is not merely filling the mind with facts; it is training the mind in observation and sound thinking, and in addition, keeping the body healthy and disciplined.

But, you may ask, what has all this to do with training nurses? If we have made ourselves clear, we are sure you will see that the education of nurses can differ in no essential from educational preparation in other professions. The same general principles must govern, or else we flounder about with no accepted compass to guide us, and reach only confusion. May one venture to suggest that part

of the chaos in the nursing profession today is due to our failure to apply accepted educational principles to the training of our under-graduates? We must not be surprised at this, because the same confusion has existed in other professions. The desire, however, to find the cause of the dissatisfaction and to remove it, which is everywhere apparent today, is wholly commendable. It is an acknowledgment that things are not right, and that the faults should be corrected if nurses are to take their natural place as properly trained participants in that vast organisation which today ministers to the health and well-being of the human race.

It may be only a coincidence, but a significant one, nevertheless, that throughout the Anglo-Saxon world, at least, those interested have gradually reached the same general conclusions, and while the problems may not be quite the same in Great Britain, the United States, and Canada, there is a unanimous conviction that the present nursing system, both within and without the hospital, should receive thorough revision.

For generations it has been the custom to speak in terms of veneration of the great service rendered to humanity by such women as Florence Nightingale and our own Jeanne Mance; the one devoting herself to nursing in Great Britain and on the continent of Europe nearly a century ago; the other, two centuries earlier still, accepting the dangers and vicissitudes of the Canadian wilderness that she might bring succor both to the native Indians and to her own fellow-countrymen. The lives of these two women, typify in a remarkable degree the ideal of service—service to suffering men, women and children. There is another side, however, about which we hear little. Florence Night-

(Note: Address to the Canadian Nurses Association in General Meeting, June 24, 1932, at Saint John, N.B.)

ingale, from her vast experience, saw the inadequacy of the nursing facilities in her own country. Prompted by this knowledge, she devoted some of her time and fortune during the latter years of her life to organising nursing schools, wherein young women could receive training in the care of the sick, in keeping with the medical attainment of the time. This contribution, while it will be always overshadowed by the knowledge of her heroism and her unselfishness, yet from a practical point of view, marked a change in nursing education. So, today, when your profession pauses to consider the many problems which the great advances in medical science have created, and the markedly changed attitude of the public toward the care of the sick, you are simply following the precedent established by an illustrious member of your profession of a bygone day.

Having accepted the broad basis upon which all education must rest, namely, the gradual training of the mind and body along accepted lines, it is necessary to adapt this principle to our present problem, so that the graduate will be, not one whose mind is crammed with fact or fiction, but one who has the resource to form judgments from observation and to think clearly and constructively when occasion arises. Perhaps you will say that this is something everyone knows. However true this may be, it is a fact, brought out in our Report, that all too many probationers reach our wards and class-rooms almost devoid of the power of observation or of reaching conclusions through a process of reasoning based upon common experiences about the sick-room.

In stating this fact, we must, in all fairness to the nurses, say that they are not wholly to blame for this situation. How often do we hear it said that all a nurse needs is a pleasant manner, a disarming smile and a sympathetic touch! We quite agree that these are invaluable natural assets, and would that every nurse possessed them in a superlative degree! This,

however, is only one side of the problem.

Wherever we go, we find splendid modern hospitals, and millions of dollars spent in research foundations. Public Health, more and more, occupies the attention of the average citizen and of governments. All this vast social enterprise is created to give effect to the efficiency of modern medicine in the care of the sick. In this complicated structure, the nurse is very properly taking an increasingly important part. Is it logical, then, to believe that she alone can be inadequately trained? Merely to state the facts should dissipate, in the minds of reasonable people, any idea that in the nurse's education the fundamentals may be disregarded. We believe that in principle the nurse should differ in no way, in her preliminary education, from a candidate for any of the other professions.

Where can this preliminary education be obtained? Undoubtedly in our secondary schools, in so far as Canada is concerned. In all the provinces approximately two years in a secondary school is the designated standard of preliminary education. We have learned, however, that wide deviation has been an all too frequent custom. Many probationers are accepted who have had a scant public school training, supplemented by instruction in a night school, business or correspondence school. Undergraduates are accepted whose scholastic attainments run all the way from this low standard to that of the graduate in Arts. It is obvious that when we accept such wide variety of mental training in the probationers entering our nursing schools, we must expect a variegated product to emerge in our graduating classes. Here, then, reconstruction should begin. It is not that a high standard should be insisted upon now, but rather that a fair standard be adopted, with a curriculum carefully worked out in conjunction with our secondary schools, so that the preliminary training will be that most suited to a young woman

about to enter the nursing profession. Having done this, make it the absolute minimum, a minimum from which, as circumstances permit, you can raise your standard of matriculation until it is on a plane comparable with that of other professions. I think I am correct when I say that along such lines education in most Canadian provinces has developed.

When students leave our high schools they do so, either to enter commercial or industrial life, or to pursue their studies in one of our universities. These students can select one of many equally recognised colleges wherein the instruction compares favourably with the best in other countries. But when the potential nurse looks about to decide where she will proceed with her education, she finds a very wide difference in the standards of training maintained by the scores of nursing schools throughout Canada. The Report indicates that at the top of the list are many that compare favourably with the best anywhere. It also points out that we have a great number that are nursing schools in name only. There are hospitals in which a young woman somewhat blindly apprentices herself, and in return for doing all the work is given some doubtful medical and nursing instruction. At the end of three years she receives a diploma showing that she has complied with the educational requirements of her Alma Mater. The tragedy of this is that in my own province, until recently, over 95 per cent. of all these graduates, applying through examination for the seal of official approval, were accepted and permitted to write R.N. after their names. So we have the efficient, well-trained nurse competing, oftentimes at a serious disadvantage, with the very poorly educated one. The public has no way of judging the difference. They are all Registered Nurses. And so the inefficient bring discredit upon the whole profession. Here, then, is a defect that should receive careful remedial treatment. Some plan of uniform

curriculum ought to be accepted by all schools. Minimum requirements, at least, should prevail throughout the various provinces respecting the size of the hospital, the average number of beds occupied, and the number and qualifications of the teaching staff, if a uniform standard of excellence in the graduates is to obtain. All these points are fully discussed in the Report. Many helpful suggestions are offered, based upon a careful analysis of the various kinds of hospitals and nursing schools in Canada.

The suggested minimum size of a hospital suitable for teaching purposes is seventy-five beds, with an average occupancy of fifty patients. Ample variety of clinical material is an essential. One might just as well try to instruct a medical student in the science and art of his profession with a few patients as to endeavour to teach nursing without an adequate number of occupied beds.

If the seventy-five bed hospital is accepted as the minimum for a nursing school, it is obvious that many hospitals now training nurses will be compelled to abandon the practice and staff their wards with graduate nurses. Objection is bound to be offered to this plan until the public is seized with the idea that a graduate nurse is something more than a maid with some knowledge of the care of the sick. In the second place, the management of small hospitals must be shown that they can conduct their institutions with graduate nurses at no increase over their present costs, provided they have been making allowance in their budgets for the maintenance of an approved school. It is quite true that a hospital can keep its costs down if it refuses to recognise that a nursing school is a school for the proper education of its undergraduates in all branches of medical science, in so far as that science is necessary and applicable in the instruction of a graduate nurse, and that such a school must be properly equipped and provided with a teach-

ing staff adequate to the responsibilities assumed. It is probable that many schools throughout Canada will say, on first thought, that if they have to provide instruction along lines such as these they will be forced to close their hospitals because of the added expense—in other words, unless they continue a low-graded school in order to give, as they believe, a cheaper service to their patients, and as a consequence of their belief, graduate nurses of mediocre ability, they must cease to exist. We are of the opinion that, from the educational point of view, such an argument is untenable, and further, that the cost of staffing a small hospital with graduate nurses in place of maintaining a modern school of nursing should be carefully investigated before any hasty conclusions are reached. Expediency is doubtless necessary at times, but it should not be accepted as an ideal and thus become dominant in practice; it tends to mediocrity in the end, and mediocrity can never be the goal toward which our lives should lead, either individually or nationally.

In this connection, I would like to point out that the hospital was originally intended for the care of the poor, more particularly those without homes whose earthly days were drawing to a close. The nursing care was provided largely by Sisters, who voluntarily gave their lives to minister to the needy sick. The development of a training school in connection with a hospital is a modern idea, and doubtless was gradually evolved as a means of providing general care for the inmates at a cost that was of necessity very low. The advance of medical science in the last half century has compelled us to alter our ideas respecting the function of a hospital. Besides providing care for the patients admitted to its wards, it is becoming more and more a factor in health education. As we familiarise ourselves with this general health problem, the more we are led to believe that the small hospital could develop a greater field of usefulness

by concentrating its energies in making itself the centre of a well-planned community health scheme, rather than in attempting the maintenance of a nursing school of doubtful educational value. It is not part of this address to elaborate such a scheme, but we offer it to those interested in health work as a field in which much can be done.

The hospital of the future must accept some responsibility for the quality as well as the quantity of its graduates, and not continue to send from its doors, into a vastly overcrowded profession, a procession of young women often very poorly equipped for duty, largely because the hospital believes that by so doing it is maintaining its costs at the minimum. We are not unaware of the high cost of sickness today, but we believe the reduction of these costs involves the solution of a problem much bigger than simply whether it is cheaper to utilise or not to utilise student nurses to do the many jobs about the hospital.

It may interest you to know that already some of the smaller hospitals in the province of Ontario have discontinued the employment of student nurses; and, further, that the Department of the Public Health, through its Hospital Section, has begun a standardisation of training schools. A syllabus of minimum requirements has been prepared, and only schools that measure up to this standard are to be approved. At the present time, about 60 per cent. have been accepted. During the past two years, fourteen of the small schools have closed; three more have discontinued the admission of student nurses; while four others have the matter under consideration, and in the meantime are receiving no probationers. Apart from the reduction in schools and the consequent curtailment of graduates, it is highly significant that some provincial governments are interesting themselves in the character of the teaching and the facilities for instruction in our schools.

It has been suggested that in the future there should be some regulation of the size, location and number of hospitals. As the provincial governments provide assistance for the maintenance of the hospitals, they might decide to withhold such assistance unless it could be shown that the proposed hospital was a social or geographical necessity, and that the economic burden would not be disproportionate to the financial resources of the community. If such a programme should be adopted, doubtless schools of nursing would be discouraged unless they were necessary in the public interest.

The same general principles that govern the organisation of a secondary school should be considered in the institution of a school of nursing. The principal ought to be a fully qualified instructress. Her staff should be composed of qualified supervisors on the floors of the hospital, together with such other instructors and technicians as might be necessary or available from the house staff. For the present, the medical staff could give instruction as might be required of them. Doubtless, as time goes on, the number of lecturers selected from the medical staff would diminish, and a few members, specially qualified for their work, could be chosen for instructional purposes. The whole personnel should be so integrated that continuity of teaching would be secured among the classrooms, the laboratories and the various wards. The necessary equipment for properly teaching and demonstrating the subjects taught should be provided. Suitable class-room accommodation ought to be available, well removed from the general commotion naturally attendant upon a large general hospital.

Early in their training, if it has not been done before, students should be required to give some time to collateral reading. In the beginning of this paper it was stated that an individual developing along accepted educational lines would keep in touch

with what is transpiring in the world outside of his own particular field. It has its broadening, cultural influence, and tends to keep in proper perspective the work of the student. Every properly conducted school should have comfortable reading-room and library facilities, where students could be encouraged to make use of the daily papers, current magazines of a wholesome type, and such books as might be available. Someone may say that the nurse in training has no time for such relaxation. Quite so, as matters stand today she has not, because she is doing all sorts of work in the wards that could and should be done by ward helpers. Heretofore, the energy of the student nurse has been exploited, in a mild way, by the hospital, to lessen the expense, as is mistakenly believed. Again, the student of the future will come to the hospital with better preliminary training and will not need to take up hours trying to learn details which she should have mastered in her collegiate or high school days. Along such lines as these, it can be shown, that, in a properly organised nursing school, ample time can be secured for cultural development, and as a result a much more efficient nurse graduated, to do honour to her school and to her profession. All this sounds formidable, particularly when the expense is considered. I submit, however, that investigation by those competent to express an opinion will show that many of these facilities can be secured at a relatively small cost. In some instances—a library, by the way—could be developed year by year, over an indefinite period of time. In fact, this is the usual method adopted in many institutions.

On the other hand, how are we going to instruct these young women if we do not provide the means? We go on, year after year, providing bigger and better schools wherein our public and secondary teachers are trained. These young men and women, the product of these splendid institutions, are so prepared that they may

train the minds of our children, and prepare them for the realities of life. Are we not just as vitally interested in the health of our children and that of our friends? Is it not just as necessary to consider the proper education of those who minister to our physical infirmities as it is to stress the training of those to whom we commit the mental development of our citizens?

If we accept the argument in favour of such nursing schools, how should the cost of organisation and maintenance be met? So far, little thought has been given to this question because it is only the very few hospitals, speaking relatively, that have considered the maintenance of their school apart from the general expenditure upon the whole institution. What is the annual cost of a student nurse to the hospital? What is her nursing value to the hospital in terms of the graduate nurse? These are questions about which there is little or no information available, and one is led to believe that a great deal of the confused thinking about whether a school or a staff of graduate nurses is the more expensive for a hospital to maintain is due to the absence of any real information on the subject. The Survey has endeavoured to answer these questions, and we suggest that careful consideration be given to the facts presented.

Should the hospital meet the total expense of maintaining the school? This is another question that has received very little attention because, up to the present, in most quarters, the undergraduate nurse has been looked upon more in the light of an apprentice who traded her work in the hospital for certain instruction which she was supposed to receive. The thought of it being primarily an educational problem has had little consideration by most people. That being the case, very few have looked upon the nursing school as a school in the generally accepted sense of the term. If, in the future, the nurse is to be educated along lines similar to those adopted by the public and

secondary schools, subject to government supervision, is there any good reason why schools of nursing should not be treated by our governments in precisely the same manner as they treat other public educational institutions? Large sums of money are contributed annually by governments for the maintenance of public and high schools, normal schools, technical schools, and your Report believes and, we think, rightly so, that the properly organised and equipped school of nursing should be treated in exactly the same manner as our provincial schools.

The Report divides itself naturally into two divisions: the forepart has to do with the education and preparation of the nurse for her profession; the latter part deals with the various aspects of her professional life. We have spent considerable time discussing the first part, as we think it is of great importance. You are asking the public to change its present attitude toward our nursing schools. It may be your hope that the school of the future will occupy some place in the general educational development of the country. Time and intelligent presentation of your cause in proper quarters may accomplish this; on the other hand, premature demands for a change will run the risk of defeating the ends which you so earnestly desire.

The patient, after all, is the central figure in this complex health scheme. To minister to him, either prophylactically or therapeutically, this social organisation which we call Medical Care has been developed. The nurse is a part of this system, but she can only function provided she is brought into proper relationship with the individual, be he sick or well. Does our present social organisation accomplish this? I am sorry to say it does not. The Survey points to the wide gap that exists between so many nurses desiring work and so many patients requiring the attention of a nurse. In Canada, 40 per cent. of the graduate nurses are

continuously unemployed, while 60 per cent. of our people, acutely ill, can not get graduate nursing care when they most urgently need it. Obviously, there is something wrong in the distribution of this part of our medical service.

The tendency all over Canada is for the nurse to seek a practice in the more populous centres. She can hardly be blamed for this, because it is the spirit of the age—the urge to leave the rural and village districts for the supposedly more alluring possibilities of the city. In times of great prosperity, the practice may prove successful, but in times of adversity the nurse is one of the first to feel the pinch, and if she can not find assistance in her home, or in some other employment, the majority have practically nothing between them and very real hardships.

Only 30 per cent. of private duty nurses save any money for the rainy day. They are not wholly responsible for this because our statistics show that, due to the overcrowding of the profession, four out of every ten are always unemployed, and thus prevented from earning a living, let alone acquiring a surplus.

These periods of depression have come and gone in varying degrees of severity as long as history has kept records, and so far as one can see they will probably continue to do so. It behooves us to make such changes in the present arrangement as will secure a more even balance between the supply and the demand, having regard to urban and rural needs, thus reducing, as far as possible, the distress attendant upon periods such as the present.

Is this change possible? In our opinion it is. The economic principle involved is simple, but its application is often fraught with difficulty. It is to adjust the number entering our nursing schools so that the number graduating will more nearly meet the needs of our population. This is not a new idea. Some years ago, many of the universities in Canada placed

a limit on the number of students entering the Faculty of Medicine each year, and some of our Arts colleges apply restrictions upon those who would proceed to an Arts degree. I do not wish the inference to be made that over-crowding, in the respective professions, was the primary reason for this action. Doubtless, it was one of a number of factors that brought about the change. However, there is precedent and that from high places, educationally speaking, for you seriously to explore the possibilities of the plan in its application to your profession.

It is not my intention to deal with the various classes of nurse, such as Private Duty, Public Health, and so on. A great deal of time was given by Dr. Weir to acquire the ascertainable facts concerning all classes. Having done so, he presented the whole matter in the Survey, with what he believed to be workable suggestions for the improvement of the general situation. We hope careful consideration will be given to the Report by the classes interested. Remember that it is your Report. The success or failure of it largely rests in the hands of the nursing profession of Canada. May we say, at this moment, that you must not be disappointed if you do not have your requests granted at once? Reform is often a slow process. It takes time for the public to become educated to the necessity of the course of action which you are advocating, even though that course may be in the very best interests of that same public. Most of us are impatient to see action. We desire to achieve reforms affecting large masses of people in our own short day. We forget the teachings of history that the present state of our social life is the result of the contributions made by the generations who have gone before.

The Victorian Order of Nurses is very favourably commented upon in the Survey: not because it is a body of super-nurses, but because the selection, supervision and distribution of the nurses are bringing very gratify-

ing results. The argument is advanced that if this is satisfactory for a small group, speaking relatively, why should not similar organisation and distribution of nursing services be carried out successfully on a much wider scale?

In the development of a service that will be adaptable to all, it is quite obvious that no plan can make possible the employment of Private Duty nurses only. That being the case, some other means of providing the necessary care will have to be found.

Our population can be divided into three classes. There is a small group at one end who, because of their wealth, can command any service they desire when ill. At the other end, a fairly permanent class who are always the wards of public and private beneficence. In between these extremes is a great body of our citizens who have not the financial resources, on the one hand, nor the desire to be the recipients of charity, on the other hand, but who do need very careful consideration in all future plans of health service. It is not always possible or necessary for them to be sent to hospital, and to engage a private nurse for any considerable time is out of the question. To this body of people the visiting nurse makes a strong appeal. I would like to urge this Association to pursue with all diligence the possibilities of such a service.

It is contrary to the accepted methods of education to have different grades of scholastic attainment in a given profession designated by the same name. For instance, a doctor anywhere in Canada is one who must have completed the required curriculum of study, passed the necessary university examinations, received the degree of Doctor of Medicine, and consequently is entitled to use the term Doctor. The same applies to other professions, and we believe that only those women who have attained the accepted standard of education in their profession should be called nurses. In time, this will be accepted the country over as designating one

who has successfully completed her student term, passed the required examinations, and is thus qualified to use the title, nurse. In our opinion, it would be just as unfair and quite as misleading to permit the unqualified women to be called nurse as it would be to allow the medical student of two or three years' standing to use the title doctor.

While we believe the graduate should have this unquestioned place in our social life, we know we are voicing the opinion of a goodly number of the medical profession when we suggest there is a place in the care of certain classes of the sick for the trained, supervised attendant. They would not be nurses any more than capable ward helpers would be doctors, but they would be trained to perform many necessary duties about the home and the sickroom under the supervision of the visiting nurse. Developed in this way, they would be recognised by both professions as trained helpers or attendants. The general public, in time, would understand the place these aides were designed to fill, and would not call them nurses nor confuse their position with that of the Registered Nurse. In the working out of your plans for the future, the non-professional aide could very well receive your attention.

As mentioned before, the necessity of bringing nurses and patients together is one of the most important problems you will have to solve. In securing this much-desired change, the present system of nursing may require to be recast or abandoned altogether. New living conditions require new methods of caring for the sick. The advent of the modern hospital, the motor car, improved highways, the concentration of large numbers of people in apartment houses, and many other present-day conditions have brought people together in a way not dreamed of three or four decades ago. Today, in most parts of Canada, acute illness is rarely treated in the private house. Indeed, much of our armamentarium against acute disease can

be used efficiently only in a hospital; hence the generally accepted view that hospitalisation of the sick is in the best interests of the patient in all acute illnesses. As a result of this view, much of the nursing service, both private duty and institutional, is centred about the hospitals. Under our present ideas of practice, all this has increased the cost of sickness to the public, until today there is a growing demand that something be done to lessen this burden upon the shoulders of the citizens of this country. We believe it is the history of such disturbances in our social life that drastic remedies are often suggested by those least informed of the intricacies of the situation. To avoid difficulty of this kind, it is the desire of the Survey that all plans for giving nursing service to those in need of it should be sympathetically and thoroughly explored. For example, is the visiting nurse to become a necessary part of our community life in the same way as the school teacher, the clergyman and the physician are now? Prejudice should have no place in this study. Present-day conditions must be studied and met, untrammelled by the customs of yesterday. While we should adhere to fundamental principles that experience has perpetuated, we must be prepared to apply these in the light of the requirements of present-day needs. The fact should not be forgotten that, while Canada is of wide extent, geographically speaking, her population is relatively small. Oftentimes long distances separate communities, while others, due to poor transportation, are almost inaccessible. In consequence of all this, it is highly improbable that any one plan of bringing nursing service to those who need it will be found applicable in all cases. These problems will prove difficult at times, but are not beyond the resources of those responsible for providing leadership for the nursing profession in Canada.

It will be found that several plans are reviewed in the Report. All of

these embrace, in a greater or lesser degree, the idea of socialisation of the nurse. Coupled with this, the adoption of some form of State Health Insurance is recommended for your consideration. That the discussion may be clarified in our minds, may we attempt to explain what is meant by the socialisation of the nurse?

Socialisation could be undertaken in two ways: First, by the nurses themselves organising their profession so as to provide a nursing service that would be adjustable to the needs of all classes of the community. Supervision would be provided and registration of all those approved for the work, whether Registered Nurses or attendants, would be obligatory. By some such plan, the hope is cherished that nurses would be permanently employed at reasonable salaries. The cost of such a scheme would have to be borne by fees from patients where this was possible, benefits from health insurance, and municipal grants. This income in time might be supplemented by endowments provided by private contributions.

The second plan would be some form of State Socialisation wherein the control of the service, in whole or in part, would pass from the profession, and nurses would be placed in the employ of either the federal, provincial or municipal governments directly, such as our civil service, or indirectly as are teachers in our schools. We have gone some distance already in socialising our nursing services. According to this definition, mostly all public health nursing is socialised. There are also large bodies of nurses engaged in school work, while many others are employed in social service work through civic hospitals and public clinics of various kinds. Inasmuch as these groups are permanently employed by the various civic bodies and receive their salaries from taxes levied upon the citizens, they are State-supported. Unconsciously, for most of us perhaps, we have accepted the principle of socialised nursing. We think we are cor-

rectly stating the fact when we say that, so far as it has gone, it has proved reasonably satisfactory for both the nurse and the public.

Are we prepared now to go a step farther and adopt the idea of either private or State Socialisation, or some combination of the two? Here the future of nursing in Canada offers a challenge to the best statesmanship in the profession because your decisions will have far-reaching effects on the lives of your members. The private duty nurse of today may become the visiting nurse of tomorrow. In my opinion, the intelligent development of a socialised plan could very easily extend the benefits of modern nursing care to many who are unable to secure it and thus bring increased happiness into many homes that are unable, for economic or geographic reasons, to participate in the full help offered by present-day medicine.

What do we understand by State Health Insurance? This is a plan—believed by many to be an advance in our social life—for providing medical care for a large proportion of the citizens of a country. It is an insurance in which the insured, together with the State, in some mutually acceptable plan, pays the premiums. When the insured becomes ill, he receives certain benefits, either in money or service, or both, and these benefits cover the expenses of the illness. By the general adoption of a plan of State Health Insurance that would include, among other advantages, a nursing service for the insured, you will appreciate how this could offer a means of extending trained nursing care so as to include large numbers of people who today are financially unable to assume such responsibility. The nursing service thus created would absorb large numbers of graduates. As such service would require to be readily accessible and continuous, careful selection and supervision of nurses would be a primary necessity. A permanent service would be obligatory upon those responsible for the system and per-

manency would mean regular duty and fair remuneration for nurses thus employed.

You realise, of course, that no restrictions would be placed upon those able to pay for private nursing, neither would nurses be interfered with who desire to follow private duty. Here, the restricted clientele would control the number desiring to practice as private nurses.

While socialised nursing and State Health Insurance may be goals towards which we are moving, I, personally, feel that at this juncture it might be more advantageous for the nursing profession if it were better organised within itself before proceeding with the larger and more idealistic plan suggested by State Health Assurance and socialisation.

As a matter of practical experience, we have found that some considerable measure of control of the profession interested, by its members, has been reasonably satisfactory. It appeals to the idea of self-government inherent in the hearts of most of us. To begin with, would it not be wise for the various Provincial Nurses' Associations to consider the advisability of seeking, through legislation, the control of the education and the discipline of those entering the profession? Modifying somewhat the suggestion contained in the Report, may I briefly outline what appeals to me as a workable plan, and one that could be explored at once in most of the provinces, provided reasonable care was exercised in the preparation of any brief that would be presented to the legislature.

Create in each province a Provincial Board of Nursing Control composed of nurses, doctors and representatives from the hospitals. The majority of the Board would naturally come from the nursing profession. Your profession being so intimately connected with and dependent upon the medical profession and the hospitals, it would be advisable to have representation from both. The Provincial Board would assume

responsibility for all matters pertaining to the nursing profession in much the same manner as the Provincial College of Physicians and Surgeons controls the medical profession within the respective provinces. The Board would have full power to enforce its demands within the provisions of the Act creating it. The Provincial Department of Health ought to be in close relationship with the Board's activities; in fact, the Minister of Health might be a member of the Board, in the same manner as he is a member of the College of Physicians and Surgeons in some of the provinces.

Among the duties assumed by this Board would be the control of the curriculum of studies to be followed in all training schools within the province; secondly, to determine, from time to time, the scope and character of the pre-nursing education necessary for a student matriculating in a school of nursing; thirdly, to control all examinations the passing of which would entitle the student to a certificate of graduation; fourthly, to fix, periodically, the provisions necessary in a hospital before a school of nursing would be approved. This Board would be the disciplinary body and would exercise reasonable control over the nurses and their relationships with the public in all matters wherein friction might arise.

Time does not permit my entering into fuller details, but we are almost persuaded that this ought to be the first development in laying a foundation for the future growth of the nursing profession in Canada. It can be proceeded with carefully and in keeping with the nursing and medical opinion of the individual province. If this was done, the expense should be trifling indeed.

In the Report considerable space is given to a discussion of a Federal Council of Nursing. At a recent meeting I was asked whether or not it would be wise to proceed with the organisation of such a comprehensive

national body at present. My personal view is that we are not quite ready to proceed with this national body, for various reasons, one of which is that it is much easier to secure legislation in your own province to render effective contemplated reforms than it is in the Federal Parliament. Having demonstrated the usefulness of your plans provincially, and thereby secured the support of your own public, you can approach the Federal problem with reasonable confidence of success. This has been the experience in my own profession and I have no doubt that it applies equally well to others. In saying this, I do not for a moment wish you to think I am unfavourable to such an organisation—on the contrary, I believe it is an ideal towards which your provincial activities should tend. In a country of such wide extent as Canada, however, with diversified interests and divided language, the problem would not be an easy one, and I feel that while this national organisation is taking form you could make progress in your individual provinces by sponsoring such changes as will assist in giving better service to those in need of it and at the same time improve the standard of your own profession. It is a big problem and the many factors entering into it will no doubt be considered very carefully by you before reaching a final decision. At this distance, we can only suggest.

The whole health problem is an intricate one. The patient makes many contacts during an illness: the physician, the nurse, the many collateral agencies that are called upon, both for diagnosis and for treatment, the social service organisation, the public health department with its corps of workers in the varied field of prophylaxis. All this and more shows how complicated has become the question of maintaining health or of regaining it, once it has been lost. In your discussions, you should keep this composite picture before you as a

guide in determining how best the trained nurse can fit in with the other factors.

A serious point emphasized everywhere today is the increasing cost of sickness. We should bear in mind that a large percentage of our population is made up of those earning a daily or weekly wage—the laborer, the artisan, and the man upon a moderate or small salary. If sickness comes into the home of such a one a serious crisis is at once precipitated. If the illness is prolonged, or if the breadwinner is the patient, a few days or weeks may bring the home face to face with difficult economic problems. Canadian statistics show that a large proportion of our families, after providing for the ordinary expenses of living—such as rent, fuel, food, clothing, etc.—can afford little or nothing for sickness. In the face of such facts, how can these citizens maintain the present accepted standards of living and at the same time pay for modern medical services unless they receive assistance from some source outside themselves? On the other hand, it is well to remember that great strides have been made in the science of medicine. Diagnosis and treatment include today many costly features that were not dreamed of a generation or more ago. So, while it is readily admitted that the cost has been increased, the service rendered has, we believe, outdistanced the added expense. At no time in the world's history

have the poor—those whom fortune has placed in our public wards—been so splendidly cared for, not only while they are residents of the hospitals, but afterwards during convalescence in their homes, or in institutions specially set apart for that purpose.

Our joint professions share in these splendid achievements. The practice of medicine—using the term in its widest sense—can never be a purely business arrangement. It must always carry with it the philanthropic side. In ministering to sick humanity, we must always minister first and at some later day seek that remuneration to which we feel our services are entitled. If compensation is not forthcoming because of an empty purse, we must be content with the knowledge that we have endeavoured to render some little service to a distressed member of our race. Such is the tradition of our calling, and may the day never come when the thought of departing from this tradition could receive the slightest consideration in our ranks. The patient, be he rich or poor, must ever remain the first thought in any plan of health service.

In conclusion, may we say that, notwithstanding the many vicissitudes through which your profession may pass, keep your ideal of service nothing less than the ideal given by the Master Himself, when He said, "Inasmuch as ye have done it unto the least of these, my brethren, ye have done it unto Me."

Life, Profession and School

By F. CLARKE, Professor of Education, McGill University, Montreal, Que.

An old friend of mine once wrote a very able book to which he gave a title wherein the word "Evolution" was used. When it was suggested to him that the book itself had very little to say about any "Evolution" his reply was: "Yes, I know, but the publishers had the title they wanted, and I had a title under which I could say what I wanted."

So much for titles. I am afraid I must offer the same kind of excuse for the title I have chosen for this paper. It is just a wide-open umbrella under which I can find room for what I wish to say.

Stated in general terms the task I am attempting is one of a perspective sketch. I wish to look at our problem of the education of nurses from the outside, as it were, so as to view it in its setting of current thought and practice, both in education and in the wider field of social and cultural tendency.

A venturesome undertaking, to be sure. For the world of thought and action and cultural movement amid which our problem is to be seen seems to grow increasingly chaotic. It is a world where, to use an Irishism, only the strong heads can keep their feet. Fortunately, our topic itself helps us. I know very little even yet about the problems of nursing education, and most of what I do know has been learned in Canada. But, coming fresh to some study of the question, I have formed at least one overwhelmingly strong impression. It is this: that no question of modern education can be more *typical*, more *representative*, of all the major issues than that of the education of nurses. Those who wish to clarify their thinking among the tangled threads of education today could find no better specific for their

purpose than a study such as we are pursuing here. For it raises, and raises inevitably, all the major issues. That in itself is quite sufficient justification for the very comprehensive report which the Survey has arrived at under the far-seeing guidance of Professor Weir. In Socratic fashion he has followed the argument wherever it leads, and he has found, as all honest students must find, that it leads not only into every department of our educational thought and practice, but into the very roots of our common culture and into the fundamentals of our social structure. Truly, we are engaged on no small undertaking.

Let me illustrate the point by mentioning a few of the issues that arise. To begin with, we are concerned, in the function of nursing, with an indispensable social necessity. Done well or done badly, the job must be *done*, and the loss is immediate if it is not well done. Here at once we have both an urgent question of vocational education and a great issue in social policy, if the necessary supply of skill is to be both forthcoming and readily available.

Then the service itself becomes increasingly technical, demanding an ever-growing degree of specialised training. Here is an issue that is disturbing us all, in almost every field of education today, and it is no exaggeration to say that the fate of society depends, in large measure, upon the wise solution of it. How are we to provide for the carrying of this ever-growing load of technical *expertise* and yet save and strengthen the human souls of men and women? A society consisting wholly or largely of "mere" experts: of people who are just experts and nothing more—what a horror to contemplate! Yet there seems to be some danger of it and the issue is nowhere more acute than in this field of the education of nurses.

(Note: Address to the Canadian Nurses Association in General Meeting, June 24, 1932, at Saint John, N.B.)

Next, we may glance at the professionalising process which gathers such strength in so many callings, in addition to that of nursing. There can be no doubt that change in the ambitions and status of women has given a powerful impetus to the process, which again, is full of danger. What is the recognised standard of competence to be? How is it to be achieved and maintained? What rights is the organised profession to exercise? How can the dangers of privilege be offset so as to safeguard the community without injury to the profession? Here are momentous questions both of education and of social control, and parallels to them can be found on every hand.

Finally, I will take note of another unsolved conundrum that is illustrated by our topic. It is of a more purely educational character and so can be used to lead straight into the main discussion. It is a question at least as old as Plato, and his discussion of it in the "Republic" is still relevant to our own case. It is this: What is to be the relation of so-called general (or liberal) to so-called special (or vocational) education?

How will that relation, when determined, be expressed, both in the educational progression of the individual and in the varied provision of educational means that the community must offer? In particular—in the case of nursing education, for instance,—what kind and degree of "general" education shall be demanded as a qualification for entrance upon specialised training? And again—perhaps even more momentous—what guarantees of continued cultural development of a broad human mind can be associated with or derived from the specialised training itself?

I call this last question particularly momentous. Why? For many reasons, the nature of which I can illustrate briefly. Are we quite sure that a preliminary course of so-called "liberal" training, given in the usual way, and carried as far as you like, is in itself a sure guarantee against

the narrowing and dehumanising influence of closely professional studies? Can we be quite sure that the "liberal" training has taken firm hold and that there will be no back-sliding? For an answer, look around on the world of successful professional people.

Again, is there any profession which requires, more than nursing, that its professional training shall itself be penetrated through and through with a rich and liberal human significance, so that the clinical thermometer and the compress become, in themselves, symbols of salvation of more than a physical kind? Can we afford to make the same cardinal mistake in the training of nurses that we made in the past in the training of teachers, where we gave the narrowest and most illiberal of trainings for what should be the broadest and most liberal of professions?

It is this need for a liberal handling of the technical training itself that constitutes a strong argument for associating at least the higher training of nurses with the university, provided always that the salt of the university retains its savour. I shall return to this point later. Here I wish to express a growing doubt about the validity of the distinction between "General" and "Special" education as it is currently drawn. The doubt, I think, goes to the root of the matter. On the one hand I see men and women who have succeeded in drawing the means of fullness of life out of the seeming technicalities of vocational training. Such people find water-springs in a dry ground. Or, like Saul in Israel, they set out on the humble task of seeking the strayed donkeys and find a kingdom. For one, the building of motor cars, for another the management of a schooner, for another the cultivation of a farm, yes, even the management of a household may become the gateway of emancipation into a satisfying life.

On the other hand, I see men and women of alleged "liberal" learning whose only capacity seems to be to go

on accumulating more and more of the same sort: walking museums, whose contents rattle more and more drily and harshly as life goes on.

Which of these has had the "liberal" training? Please do not misunderstand me. My point is not to decry so-called "General" education: anything but that! It is rather to emphasize the view that a course of education is to be judged by its product rather than by the content of its programme. That is liberal which produces the liberal and special which produces the special. And the difference is quite as much a matter of spirit and atmosphere as of formal content on paper.

I think we have here *the* crucial educational issue for a modern democratic community where each must discharge his proper skilful task, and all must share in, and contribute to, the common cultural life. We have not really faced the issue yet, largely because we have been obsessed by a formal distinction between the liberal and the vocational, which is largely traditional, and exists today very much on paper.

Let me illustrate by a direct question: What percentage of the young people of our universities—yes—even in our high schools—are there, in the last resort, for any other than a vocational motive? Insistently, in season and out of season, we have linked formal education with *success*. That has been our real faith, our real working philosophy. Some of us have gone so far as to work out laboriously and in true modern fashion the comparative cash value of various levels of education; public schools in hundreds, high school in thousands, and university in tens of thousands of dollars. And our young people have responded. Why should they not, to a faith which their elders hold so fervently? No wonder that, in their secret hearts, many of them look upon our fine "inspirational talks" about the value of education in itself as just so much insincere bunk.

The Nemesis for all this may be already at the door. I shall be immensely relieved if the next few years do not bring a violent popular reaction against the whole of our elaborate provision for formal education in school and university as a huge fraud. Unfair, no doubt, but it will be one more charge of the younger generation against the older that the latter has held out promises which it cannot fulfil. The donkey has made the painful journey and there are no carrots at the end of it. It is a little late in the day now to turn and rebuke the donkey for worldliness and to assure him that he has his reward in a much more spiritual and lasting sustenance than carrots.

Clearly it is the philosophy that is wrong, particularly wrong in the insincere guise of idealism behind which it hides the true grossness of its inspiration. In truth, where our effort should have been to liberalise the vocational we have succeeded only in vocationalising the liberal, and have fouled the feeding trough of culture in the process.

The fundamental revision of values that is called for will have to extend far beyond the field of education in the formal sense. Here it is enough to repeat that, largely because of this failure, modern democracy has hardly begun to solve its real problem; since neither in the individual life nor in the life and culture of society as a whole has it succeeded in integrating the Useful and the Satisfying; the Necessary and the Fine; the Vocational and the Human; the Specialist and the Man.

Spurious solutions are around us in plenty. Among them one might mention Efficiency, the ideal of triumphant techniques: "Service," offered usually only in return for a dividend, and combining, often unpleasantly, the lubricating grease of business with the treacle of sentimentality—even at its best its weakness is apparent in its vagueness; then the ideal of the "Good Mixer," in which

I feel at times the philosophy of Professor Dewey seems to culminate; or again, the ideal of Conventional Conformity of the "Hundred-Per-Center," which, one might gather, is satisfying to so many.

The real inadequacy of them all is evident in the vast reservoir of dissatisfaction that they leave behind, like a lake at the foot of a glacier. The lake is now growing turbid and agitated and threatens to give rise to a torrent. Its presence and the menace of it is the measure of our problem; a problem of education through and through since the threat comes not from an outside source at all, but from the bewildered minds and consciences of men and women who feel themselves betrayed by the old gods, yet need strength and guidance in the painful task of finding more satisfying objects of devotion.

Note again, then, how typical and representative our problem of nursing education is, set in the midst of a society where men are in danger of losing their souls in a vain effort to gain the world. Nursing, with the intense humanity of its mission, the wide diversity of its contacts with the life of men, and the combined concentration and sympathy that it calls for in those who practise it: is any profession more concerned with the supreme task of keeping body and soul together in much more than a merely physical sense?

So the claims of nursing education offer a most favourable ground for testing out the validity of our principles. To that task we will now proceed—the consideration of the education of nurses as a model for the whole problem of an integrated education that will keep body and soul together, unify life and vocation, and build a well-proportioned scheme of values so as to guarantee richness of life without prejudicing wholeness and effectiveness.

First, then, as to *objectives*. The chaos about aims which now characterises the educational field is but a reflection of the wider chaos that

is paralysing Western civilisation as a whole. We seem to be passing through the profoundest moral and spiritual crisis that mankind has experienced since Greek times, and no man can say what will issue from it. I do not propose to go into its causes: they are a matter for the interpreter of modern history. Nor do I doubt that we shall come through: Western civilisation is not going to collapse. Here, however, I ask you merely to take note of the fact itself, patent as it is to us all.

A solution of our deep and painful perplexities cannot come wholly from the educational end. But it must, very largely, begin there, and it can hardly come at all unless those who have charge of education achieve a pretty clear consciousness of the direction in which a solution is to be sought. The burden of the pioneer and the scout is thrown upon the educator today as never before. He cannot escape the responsibility for a leading part in the drastic revision and re-integration of Values that is called for, and in the building up of those stable and adequate *Standards* that we so sorely need. Even so, his power may not be equal to his vision; his reach may exceed his grasp. But that is hardly his fault.

Let me repeat that the root problem is moral and spiritual, one of the reconstruction of stable values, and of a sure discipline to achieve those values.

I should like to be allowed to illustrate our problem by reference to three recent books which, for me at least, when taken together, state the issue with a most helpful clearness.

The first is H. G. Wells' "Work, Wealth and Happiness of Mankind"; the second is Aldous Huxley's "This Brave New World"; and the third, D. H. Lawrence's "Apocalypse."

Mr. Wells' book is the last member of his trilogy on the foundations and prospects of our modern world, the other two members being his "Outline of History" and his "Science and Life." This latest book may be

not unfairly described as a glorification of the practical ingenuity of man's intelligence and of the unlimited possibilities that lie open to his inexhaustible inventiveness. The note of the book is strangely reminiscent of the voice of King Nebuchadnezzar as he walked in the palace of the Kingdom of Babylon: "Is not this great Babylon that I have built for the house of the Kingdom by the might of my power and for the honour of my majesty?" We know what the consequence of that performance was, but Mr. Wells shows no sense of it at all in the analogous case. The prospect he paints is that of a vainglorious and rather vulgar Triumph of Technique. Witness, for instance, the snap and click of the highly polished "Efficient" Parliamentary system that he devises. The crucial word "Happiness" occurs in his title, but it is nowhere defined in the text, nor does it occur in the index. Neither does the word "Character." We are left to assume that the Triumph of Technique is Happiness, and Art, Poetry, Literature are handled in a very brief section where they are treated as the expression of man's superfluous energy.

Salvation comes, therefore, through engineering! Yet, inadequate, and indeed degrading, as the Wellsian conception is, it, or something very like it, serves as a seemingly satisfying ideal to many at the present time.

Aldous Huxley's "This Brave New World" is a biting study of the Wellsian ideal come true. Science and technique and the calculating intellect have triumphed: war and disease, poverty and maladjustment are no more: even the pangs of birth and the risk of misfits have been circumvented by elaborate pre-natal treatment which utilises all the latest in bio-chemistry. To utter the word "father" or "mother" is now the height of obscenity.

All the ills and disagreeables have disappeared. But so also have all the deeper satisfactions. There is no friction, no striving, no rising from the

ashes of failure to new efforts at self-making. Poetry has sunk several grades below doggerel, and music has disappeared to give place to direct titillation of animal feelings.

The intrusion into this world of a savage, who has, by accident, got hold of a neglected Shakespeare, causes a riot and, incidentally, gives Mr. Huxley the chance to say what he thinks of it. The whole thing may be summed up as: *Pigs*, without even the excuse of dirt.

Whatever one may think of the details, the moral of it all is clear. The conquest of war and disease and poverty is not the end of our problem, but the beginning of it. When we have got thus far we shall be faced more nakedly than ever with the inescapable problem of the Art of Life itself. Man can use science to conquer ills; but he can also use it to condition himself so as to become quite insensitive to the whole range of what we used to call the "higher" values. Is he to describe as "Happiness" the well-washed but brutish contentment that might ensue? Is it not rather the case that Beastliness *plus* the clinic and the bathroom is Beastliness still; if anything rather worse than the primitive unwashed kind?

That seems to be Mr. Huxley's moral, and some current tendencies in life and education seem to be not a little concerned in it.

The third book, D. H. Lawrence's "Apocalypse," is the profoundest of the three. It is such a passionate unity and it makes such efforts to use language to express the inexpressible that quotation is hardly possible. But its general burden is plain. Lawrence puts his finger on the overgrowth of the inventive intellect—the Logos, as he calls it—as the root cause of our modern disease. His own self-torment in the search for a remedy should warn us that the quest is not easy. Also it is full of danger, as Lawrence's own writings show. Fullness of life is made to look like a perilous walk along a sort of knife-

edge with a chasm of beastliness on either hand, that of Caliban on the one side and that of Babylon on the other. But there is good Christian precedent for such a view, without involving ourselves in the negations of Puritanism.

For our present educational purpose it may be enough to say that what we are faced with is the need for an infinitely delicate and pliable *discipline*, that can be diversified and variable in its play just because it is so sure of its end, and that can guarantee freedom and fullness without falling into sophistication. I want to stress this word "Discipline," as the necessity for it seems to follow from all that has been said about the lack of true and adequate standards and the chaotic operation of false and inadequate ones. Reach agreement upon standards and the discipline follows. Hence I think it is not untimely to state our problem as one of the Reconstruction of Discipline. The point is important in the present connection just because of that peculiar *representativeness* of nursing which I have already emphasized. The nurses professional *expertise* will be a poor and shrivelled thing—it may even be a dangerous thing—unless it springs from and is rooted in a large and liberal human discipline such as we are now contemplating. She is the representative of a culture as well as the bearer of healing, and she cannot well represent what she has not learned to possess.

Now this word "Discipline" is not popular today. I know. But that is largely because of the company it has kept in the past. When we hear it we think of its old, unpleasant associations without pausing to analyse its real and necessary content. But to purge and reform the concept is one thing: to throw it away is quite another thing, as calamitous as the proverbial throwing away of the baby with the bath. For *all* education that is not a blind and cowardly surrender to whim and impulse is discipline. It involves always a choosing of this

rather than that; it is indeed one long series of choices of the better over the worse. Where there is choice there is a standard, explicit or implied, and that standard is conceived in terms of the good of the disciplined one. The old discipline erred in method rather than in end. It took too little trouble to secure an *internal* discipline, to identify the positive will of the pupil with the aims of the tutor, and so with his own good. For it, the will of the pupil was the obstacle, not the hope. John Wesley, when he urged an anxious mother to "break the child's will" at all costs, was wholly benevolent in his intention; we can hardly say he was wise in his method.

What we have to do with the concept of discipline, therefore, is to revise its method, not to throw it away. It is by no means the only example of a salutary idea that is apt to be thrown away in these heady and oversentimental times just because of past prejudices and because we lack either the wit or the will to make a right use of it.

Our notion of a Reconstruction of Discipline implies, then, a comprehensive ideal of self-building that will give to both individuals and society a satisfying moral and spiritual *shape* within which all the fullness of diverse human possibilities can be realised. The Greeks had such an ideal of shape—within limits. Mediæval Christendom had one too, also within limits. But the course of the last few centuries of history has been all against any reconstruction of it. Yet it is what we are all fumbling after in blind and somewhat perverse fashion. If ever we do again achieve some approach to such an ideal it will have to be something far richer and wider than any such ideal has been in the past. For it will have to cover a much wider range of human possibilities; it will have to include and provide for a vast number and variety of individuals; above all, it will have to provide for a discipline that is freely ac-

cepted, positive and *internal*, if it is to satisfy modern man.

But we must achieve it if we are to educate at all with effectiveness and confidence. Without it, education becomes either the application of false disciplines to distort a natural humanity, or a sprawling, shapeless, aimless thing with no discipline at all and hiding its real nature under a mush of uncritical sentimentality about "Freedom."

When it becomes possible again to apply in Education a full concept of Discipline, fearlessly and confidently, we shall see a considerable shifting of emphasis among current ideas. Thus there will be less of problem-solving and more of the heightening of sensibility and awareness; less of interest-following and more of willing and choosing; less of the group-activity and more of the contemplative self; less of either license or prohibition and more of self-restraint; less of endless invention and "re-making" and more of absorption in and attunement to an ideal that finds expression all around. We shall move, that is, away from a misunderstood Rousseau towards a better understood Plato. We shall depend less upon things and more upon ideas; we shall gain in quiet sensitiveness without losing in eager curiosity.

If we can restore a large and liberal conception of Discipline in this sense our problems of vocational education will be solved in so far as their solution depends upon an adequate preliminary general training. Where all are trained to respond actively and sensitively to the values of a rich common ideal, with a training which runs less risk than ours does today of degenerating into an aimless and meaningless scholastic ritual, the subsequent vocational preparation will have in view not the *compartmentalising* of a little special corner of the common life, but the expression of the common life as a whole through one of its typical functions. The thought is quite Platonic in spirit. The nurse is the community nursing;

the teacher is the community teaching; the tailor or cobbler the community patching; and so on. In our present divided, chaotic, undisciplined state the thought may seem visionary enough. Nevertheless, the attainment of something like it is the key to the true solution of all our problems of educational objective.

My reason for dealing thus fully with this fundamental matter of a General Discipline should now be sufficiently clear. The picture would be wholly incomplete without it. I have been struck by the emphasis that experienced nurses themselves place on this matter of general education. They realise, I think, that nursing does not take place "in vacuo" as it were. It involves close and peculiar contact with human beings in a condition of peculiar need, and the strenuousness and tension which are involved in its pursuit call for a personality that is peculiarly rich in inner resources and the means of preserving balance and sanity. In a word, it calls in a pre-eminent degree for just those refined and developed human traits that it is the business of liberal education to provide. Do I not claim rightly that no better and more representative field for testing out our principles can be found than this of the education of nurses?

So much then, at least for the present, for the all-important foundations. What of the special vocational superstructure, the training of the nurse as such?

Here you have for guidance the rich resources of the Survey Report, so I need do no more than touch upon some of the main considerations. I will speak first, briefly, on the social implications, and then, at somewhat greater length, of the Educational necessities.

Concerning the relation of the nursing function to the structure and functioning of society as a whole, I wish to say quite definitely that I see no hope of a final and satisfying solution of the problem of training unless the health services of the community

are de-commercialised. The problem is simply insoluble unless this is done. I have often noticed the curious fact that debates on professional questions—even among teachers and professors—frequently turn out to be, in reality, just conflicts of vested interest. So long as the commercialised competitive basis persists, so long will the human and social value that should dominate training tend to be vitiated at their source. Even if the instructor sees straight, the pupil will be tempted to look askint. The universities themselves are not free from it either, unless we are to believe that every Ph.D. degree is sought with a single eye to the advancement of learning. I know nothing more melancholy in a teacher's life than the watching of this "contagion of the world's slow stain" as it creeps insidiously but deliberately over pupils in whom he thought he had seen capacity to resist. The evil is only made worse by hypocritical unctation about "service."

It is not for me to say how the socialisation should be effected. I merely lay down the principle as necessary to a full and worthy achievement of the educational end. But I would like to add just a word about the alleged "loss of the spur of competition" that would follow upon socialisation. This contention impresses me as a melancholy instance of our customary failure to think comprehensively and disinterestedly on those great social issues. Two things can be said about it. In the first place, to what *kind* of competition is the present order of things a spur, competition for the advancement of professional practice or competition for the material advancement of individuals? Some material for an answer might be had from an inquiry into the sources of advancement in medical and health practice during the past century or so. How many of the advances have originated with purely "competitive" practitioners?

In the second place, would there be no competition under a socialised system? The question answers itself. But,

of course, it would be competition of a different kind.

Really I am more than sceptical about this argument of "competition," in the 19th century economic form in which it is usually put. At times it almost seems to be equivalent to an assertion that the human aspiration towards excellence will not function at all except at the lure of gold. Yet, all experience of genuine human service belies it.

I turn now to speak more specifically of the scheme of training that is implied by our double objective of a vocational adaptation growing out of a live and strong general culture.

The Survey Report, in the comprehensiveness of its range over the whole field, reminds me a little of the famous "Institutio Oratoria" of Quintilian where he discusses the training of the orator. He begins by getting his subject satisfactorily born, and does not think it irrelevant or unseemly to discuss the details of the regimen of infancy. For it all belongs, since "Orator nisi vir bonus, non potest." The Survey seems to think much the same about nurses. True, they have to be made as well as born, but the making goes on from the first and there are certainly some who are born *not* to be nurses.

Again, note the *representativeness* of this matter of the education of the nurses. It is one well-marked instance of the whole general process, and the Survey is entirely right in bringing to bear upon the problem wherever it can, the best of our ascertained knowledge about the educative process.

You will not expect me to discuss the infancy regimen of the embryo nurse as Quintilian discusses that of the embryo orator. But it is not irrelevant, and as a father of five daughters I might claim to have a few ideas about it.

However, I must concern myself here with the more strictly scholastic preparation. The field can be divided conveniently into three parts or

stages. The first I will call "Cultural Saturation"; the second, "Specialisation"; and the third, "The Higher Training."

What I mean by "Cultural Saturation" should now be sufficiently clear. I will not call it the dipping or dyeing process as that makes the subject of it too passive. But it is something of that sort in its effect. What it does is to produce the live, alert, self-conscious *type* of a culture, which, if not yet fully developed, is full of the promise of rich and many-sided development. Of course, in Canada, the cultural constituents will have their Canadian flavour, but I see no serious danger in Canada of a narrowly interpreted Nationalism restricting the possibilities of a broad human culture. The charge is rather the other way; incoherence and shapelessness and lack of a clearly defined sense of what it means, culturally, to be Canadian. But a touch of adversity seems to have made the omens more favourable and there are welcome signs that the whole common life of Canada may draw itself together in a more self-conscious unity, fruitful in suggestion and guidance and disciplinary influence for all its members.

However that may be, the possibilities depend on forces that are beyond the immediate control of the nursing profession as such. The practical question for us here is to decide what degree of saturation, such as is now possible, the candidate nurse should attain to.

We cannot go behind recognised certificates of scholastic standing. Admitting all their defects and dubieties, we must allow that efficient conduct of mass education requires them. Remedies for defects must take the form not of discarding these holding-pins so as to let education down in a shapeless sprawl, but of improving and enriching the culture to which they testify, and of fighting relentlessly against the tendency to exaggerate the cash value of a certificate as such. High school leaving stan-

dard seems to be the best we can hope for just now, and where high school training is good it may be sufficient. For we must not forget that the next stage, that of vocational specialisation, should keep open many possibilities for further culture.

May I add that I disagree with the Survey if I understand rightly that it advocates a special *ad hoc* Nurses' Matriculation? This would be a retrograde step: the adoption of a practice which other professions have discarded. The time for what I call "Saturation" is all too short: its value for the subsequent training is due to its being what it is, a general culture; and as one who has suffered from it I deprecate these all too early predestinations:

"Oh! If we draw a circle premature,
Heedless of far gain,
Greedy for quick returns of profit, sure,
Bad is our bargain"

I would rather see a lengthening of the professional training should that prove necessary.

Coming now to specialised professional training, I notice that there is a tendency among nurses to speak rather bitterly and contemptuously of what is called "Apprenticeship." I hope I shall not be thought unsympathetic if I suggest that on this point we should think again. I know well the evils of a system that subordinates the paramount claims of genuine training to the exploitation of cheap, immature labour. I had a little to do with that fight in South Africa in helping to build up the semi-State system of educative apprenticeship that is now in operation there. Also I have been through it myself. I served my four years as a very juvenile apprentice—a pupil teacher—in England in the bad old days before the reforms of 1902. I know how much drudgery and how little education there may be, how much premature responsibility, how much lowering of standards of achievement and stifling of the wider powers.

But have we not here a case like that of discipline; a true idea perverted and misapplied by a mistaken

and vicious method? Is apprenticeship still wrong when the claims of education are made really paramount, when the pupil is first and foremost a learner and a young worker only *because* he is a learner? For what is the alternative to apprenticeship? Can it be anything but a school? Faith in schools is apt to be strong when belief in education is weak. Everywhere their severe limitations as instruments of true vocational training are becoming better understood, and recourse is had to training-on-the-job, with a specialised kind of school playing a subordinate though necessary part. Do not let us, then, discard the concept of apprenticeship. It is the right notion. Let us rather purge it of its bad economic associations and of the abuse of methods that has so often gone with it. The Survey Report makes excellent recommendations on this point, which I need not repeat. They seem to fall under two heads: (1) The organisation of adequate teaching institutions. These can only be hospitals with properly equipped schools attached to them. (2) The provision of properly trained teachers. There is a new profession here, which will have a great part to play in the future. Whatever we may be able to do here at this conference, the real task will be theirs. They will be key-people discharging a most vital function, and I trust that the coming organisation will be flexible and liberal enough to give them proper scope. In the parallel case of the State schools the teachers have still not achieved their proper share in the making and execution of policy. I trust that hospital boards or other governing authorities will be wise enough to guarantee the "*libertas docendi*" of those upon whom the main task must fall.

But over the whole of this scene of the specialised training I see again the spirit of socialisation asking for embodiment. And the claim grows the more insistent the longer I look at the problem.

May I add that, if the training schools of our dreams should really get going, I should look to them to make significant contributions to our knowledge of educational principles and technique? Working in so rich a field, where there are so many points of contact with varied human interests, and guided, as they would be, by highly trained directors, they should yield much that would be of value to us all.

Again, do you observe, that note of *representativeness*!

I come, finally, to what I have called the "Higher Training." The meaning of the term will be clear to you. It refers, of course, to Instructors, Administrators and Directing Staff generally. It is here that I smell the smoke of battle, for intensely agitated questions like that of the proper scope and function of universities and that of the rights and status of what may be called the higher professions for women here come upon the scene. So you will forgive me if I tread a little warily. I am prepared to accept right away certain propositions about the training that is called for at this level, the training in a School for Graduate Nurses, if you like. These propositions are:

1. That the training is of unquestioned university level.

2. That it requires urgently the university atmosphere of breadth, leisure and disinterestedness.

3. That those who will take it are beyond all question of university standing. I can speak from a little experience here, having been brought in touch, academically, with groups of students in a university school for graduate nurses. It seems almost like insulting them to give the assurance that I have been struck again and again by the strength and maturity of mind that many of them displayed, by the keenness of their interest, both professional and intellectual, and by the value of such an experienced leaven in the general student body.

But it does not necessarily follow from my acceptance of these propositions that I should agree to the further propositions:

1. That the universities should assume sole responsibility for such training.

2. That successful completion of it should be marked by an *ad hoc* degree for nurses as such.

Note that my attitude is non-committal. I do not deny these two last propositions, but neither do I wholly affirm them. There is a fence-sitting attitude for you! Say that if you will. But many things have to be considered. Let me mention a few of them.

1. You may look for, and find, the subject "logic" in the curricula of universities, but you must not expect to find it always in their policy. They, like other institutions, are the creatures of circumstance, and history and accidental pressures, and it does not follow that what they have done once they will do again. With them, as with politicians, the chill of practical necessity may make them insensitive to the fervent heat of logic. Law, Medicine and Theology have their place by ancient practice: Engineering and Architecture are well-established new-comers: Commerce, pushful as ever, is getting well in. Now comes a situation not unlike that of the recognition of denominations in public education—if one sect why not all the rest, and how many might there not be?

2. This necessarily raises acutely the question of the real purpose of a university, that function which it must always put first in considering competing claims. There is debate enough on the question today when universities tend to disappear in a congeries of technological schools. But my own mind is quite clear that the true value of universities will be lost unless we put first the functions—the

purely *cultural* function—of saturation, as I have defined it, and the creative function of Research. These, I think, must always have first claim.

3. But this need not mean the complete exclusion of all further professional schools. The problem is largely one of finance. The university's attitude might be different if it did not feel it was robbing its own child Peter, to pay a step-child Paul. Is there no possibility of founding schools rather like theological colleges, in close affiliation with universities but with no financial claims upon their general funds? The practice is by no means unknown and some major difficulties might be obviated if it could be followed.

4. As for the degree, if that is demanded, various courses are possible. The wide umbrella of Arts or Science might be capacious enough to cover a very satisfactory degree for nurses. For have I not all along been emphasizing the central representativeness of the nursing profession and its education?

Or the school might give its own qualification with the university's imprimatur. I agree that the issue is largely one of professional status and there may only be one way—that of the nurses' degree as such—to secure the object. But as yet I remain unconvinced.

5. Greatly daring, I venture a last point. What of the future of university degrees in general? "When everybody's somebody, then no one's anybody." Sometimes I long for that day to come, when, with a tremendous slump in the value of university degrees, it may be possible to tempt young people to turn away from pot-hunting to the serious business of their own education. "A man's first social duty," says a wise American, "is his own education." I agree heartily that a great and vital social function like nursing,

where the training must be severe, and the work is often arduous and thankless, calls for adequate social recognition. And I agree, too, that such recognition is, to some extent, a factor in efficiency. But in that more rational and better socialised world towards which we hope we are moving standards of valuation may be different. We may learn better to value people for what they are and for the significance of their service rather than for their labels. The salesman and the advertiser will not always rule, and those who have lived with the most satisfaction to themselves and the greatest benefit to mankind rest generally in unvisited tombs.

This may sound like cold comfort, and I may myself be accused of offering the labouring animal spiritual sustenance because I am not prepared to let him have the carrots. Carrots are sweet and pleasant nourishment, but they are not the same thing as a faithful journey. God help us all to know our true reward.

In conclusion, may I say that I value very highly the opportunity you have given me for thus addressing you? I ask your pardon for any-

thing amiss that has been said, and for omissions of which I may have been guilty. But I have tried to put before you a few inadequate hints towards a guiding philosophy, and I know you will be able to take what is fruitful and leave what is barren.

I close on the note with which I began; the thoroughgoing human representativeness of nursing. I have had the privilege of its ministrations as I have had the privilege of teaching some of its ministers. I have tried, to the best of my ability, to offer some help in the solution of its training problems, and I am left now with a great hope and a great confidence. For your work carries you right into the centre of this human scene, to springs of emotion and action to which many of us cannot penetrate. As I think of the burden laid upon you, I recall that well-known verse of Blake:

"To Mercy, Pity, Peace and Love
All pray in their distress,
And to these virtues of delight
Return their thankfulness."

I can offer no greater tribute to the nursing profession than to say that reflection on its mission and its problems makes me think of that verse.

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The Scientist and the Survey Report

By ROY FRASER, Professor of Biology and Bacteriology,
Mount Allison University, Sackville, N.B.

I am very greatly honored by your invitation to address this Association, and particularly so because this Saint John meeting is the most momentous convention in the history of Canadian nursing. The eyes of the nursing world are upon your deliberations, for by your transactions there must be laid the foundation of a new structure that will increase the power and scope of the already splendid achievements of your profession.

If you expect me to make the conventional sort of after-dinner speech, or that what I say will have any entertainment value, then I must ask your forgiveness for disappointing you.

But the instructions of your Programme Committee imply that that is *not* your wish, for you have charged me with a very specific duty,—that of discussing the Survey Report from the viewpoint of a scientist.

That places upon me the eternal obligations and limitations of my profession,—those of telling the truth as I see it, of searching out a few significant principles from a great mass of facts, and then presenting my conclusions in the plain and unbeautified form of the summary of a scientific paper. You asked for it; now you're in for it. But I'll try not to be too prosy, and if I can contribute even one useful idea, one constructive suggestion toward the improvement of nursing education, then your time will be better spent than it would have been in listening to the usual verbal pyrotechnics of the habitual after-dinner speaker.

I shall divide my remarks under four headings:

1. The Survey Report
2. Pre-nursing Education
3. The Nurse and Health
4. The Nurse as a Woman.

1. The Survey Report.

It is not flattery but honest praise and straight from the heart when I say that the Report represents the finest piece of survey work I have ever seen in my life. I have no words adequate to express my admiration for the vigor and directness of its attack, the methodical and well-ordered presentation of its findings, and the sanity and cogency of its reasoning,—a piece of work that would warm the heart of any scientist.

And it is not only good reporting but, by all the gods, it is good literature!

Your Committee deserves the gratitude of the nursing and medical professions, and of the public, for the way in which it has carried out this great task of surveying and analysing the conditions and problems of an entire profession.

You were most happy in your selection of a Director, and fortunate in securing his services, for I say in all sincerity that there is no man in the Dominion of Canada who could have conducted that Survey with greater efficiency or more inspiring leadership than did Professor George M. Weir. As a member of the guild of university teachers, I am naturally proud of this splendid achievement of my fellow teacher, but I realise—as Professor Weir himself would be the first to say—that he had associated with him a committee of nurses and doctors of the highest distinction in their respective professions.

Without such a general staff, no one field-marshal could have carried through such a great campaign so successfully. The Committee, in turn, were well served by a co-operating army of thousands of nurses and doctors throughout the land. What a fine sense of mutual helpfulness exists in those two professions; each is not only the complement but the comrade of the other, and I think that I can read

between the lines of the Report something of the fine spirit that made the Survey possible.

The Survey Report is primarily an educational document. It deals with many other issues that affect the nurse, but as the title of the Report implies, the chief concern of the Survey has been to study present conditions in nursing education, to determine the virtues and defects of the present system, and to recommend those reforms which are obviously needed if nurse-training is to be brought into accord with modern educational ideals and methods.

"Aller guten Dinge sind drei," said Goethe. So I shall select from the entire Report the three outstanding reforms which, in my opinion, are made imperative by the facts presented, and which must be pre-requisite to all other reforms:—

Point One: (page 301) "The exploitation of the student nurse under the guise of educational training should be stopped. The approved training school for nurses should be considered primarily as an educational institution rather than as an economic asset to the hospital." In the whole length and breadth of the Report there is nothing that takes precedence in your programme of reform over the postulate stated in those two sentences. Start out to carry that point; keep fighting until you *do* carry it; and the day you carry it you will free our training schools from the greatest injustice under which your profession has to labor.

If you think that is strong talk, you will find stronger talk in the address given by Dr. E. P. Lyon, Dean of the University of Minnesota Medical School, before two state association meetings of registered nurses and published in the March, 1932, issue of *The Canadian Nurse*. I do not agree with Dr. Lyon that all the problems of nursing will be solved by divorcing its educational and economic aspects, but I do most heartily agree with him that this step must come before all

other steps, and that all the others are in a large measure contingent upon it.

Point Two: The rigid selection of fewer candidates, and better ones, for the student personnel. On the academic side, the candidate must have nothing less than Junior Matriculation or, preferably, the proposed Nursing Matriculation. Any young woman who has not enough mental ability to make Junior Matriculation standing has no business in a professional school (will you show me any other skilled profession that would permit it!) and no institution has any right to permit a student nurse of inferior intelligence to assume the care of the sick. Modern scientific medicine demands that under no condition shall the safety of human life be entrusted to the mentally incompetent.

The foregoing or academic selection may and should be made according to standards uniform throughout the land. The appraisal of personal fitness, however, can not be standardised, and must be determined by training-school officers of the widest experience and soundest judgment available.

Point Three: The employment of nothing but full-time permanent instructors in all training-schools. I am quite aware that in this third point I am going far beyond the recommendations of the Survey, so please blame me and not the Survey. In order that Professor Weir may not catalogue me among the ultra-progressives, and also to escape from the wrath of those present who are experts in the field of hospital budgets and staff administration, let me admit freely and frankly that this third point is decidedly impracticable under present conditions, and that it will take a long time to bring it into action.

Granted, but I must also insist that if the educational principle involved be sound, then neither the limitations of the present nor the reconstructive difficulties of the future can ultimately prevent it from coming to pass.

The principle is absolutely sound and its demands are inescapable. The very haphazard hit-or-miss methods of instruction which prevail in some of the smaller training-schools today are neither educationally sound nor practically efficient, and they result in something far worse than honest ignorance, — namely, institutional sham and pretense, issuing a counterfeit coinage of scanty, irregular, superficial “teaching” and passing it off for the face-value equivalent of the better instruction given in the larger schools. All small schools are not culpable in this respect, nor are all large schools necessarily satisfactory, but having granted these exceptions, the fact remains that there are far too many cases in which the criticism is perfectly justified.

Whether the school be small or large, I hold that the only person who is qualified to give proper teaching is that person who has made it a life work, who has mastered not only his subject but also the technique of teaching, who continues to specialise permanently in such teaching, and who adds year after year to his experience in the particular methods and problems of nurse-training. The “occasional” lecturer, the temporary teacher, the half-trained and inexperienced instructor, the mechanical technician-trainer,—these are all too familiar figures in some of our schools, and as long as they are used as a cheap substitute for qualified full-time instructors, so long will the attainment of high training standards be difficult or impossible.

We need only state one argument in order to defend this thesis successfully against every conceivable criticism, namely, the fundamental ideal of medicine which holds that as long as human life is sacred, so long is it our responsibility to protect the patient from all incompetence and inefficiency in the medical and nursing services upon which his safety rests, and if what I said under Point Two concerning mentally incompetent students be true, it is equally true when

applied to pedagogically incompetent instructors. The efficiency of the nurse will be conditioned very largely by the quality of instruction she receives, and we dare not give her less than the very best.

“Where will the money come from?” It will come from the same place that the money for all the rest of our educational institutions comes from, and you will only get it by doing what our educational pioneers did — by fighting for it. They won their fight because they had vision and courage and determination, and you will win yours for the same reason. There *are* some reactionaries and obstructionists in Canada today, but they are not numerous, and you are; they are not organised, and you are; they have no wise leadership, and you have; they have power to impede or delay your reforms, but they will find in the end that they are *not* as powerful as a highly-organised army of professional women, stretching from coast to coast, and known as the Canadian Nurses Association.

2. Pre-nursing Education.

The idea of a university course of pre-nursing education which I am about to outline is not my own. It was suggested to me last year by my faculty colleague, Miss Lilian Hart, R.N., who also gave me a tentative outline for such a course. Miss Hart later brought to my attention an address published in the January, 1932, issue of *The Canadian Nurse*, which Dr. Clowes Van Wart of Fredericton had given before the New Brunswick Association of Registered Nurses, and which was in some degree comparable with the plan devised by Miss Hart.

Miss Hart's suggestion is, in brief, that the clinical training of the nurse be preceded by a pre-clinical course of one year in a university, somewhat similar in principle to the pre-medical training of medical students, but also including in addition to the basic sciences most of the theory lectures which now overburden the nurse during the period of her practical train-

ing, and which in their present form and position are so at variance with proper teaching methods.

Dr. Van Wart suggests that two courses be offered, as follows: "Course One would cover a professional curriculum of eight months at a university and three years at a standardised school of nursing. This course would lead to a Diploma in Nursing. Course Two would cover a professional curriculum of two years and four months at a university and three years at a standardised hospital. This course would lead to a Bachelor of Science degree in Nursing."

Dr. Van Wart has given us an idea well worth studying. I think, however, that his second course, extending over a period of five years and four months, is too long for present acceptance.

Moreover, I can not feel that a degree should be the objective of any nursing course. In saying this, please don't think that I am lacking in respect for existing university nursing schools where degree credit is given. I am loyal to the ancient traditions of the university world, and it is because I *am* loyal to those traditions that I feel bound to deplore the present craze for degree-seeking and the quantitative method of degree-granting.

A degree once meant that the holder thereof sought and mined and loved the pure gold of learning, but today—we have gone off the gold standard. To vary the figure, we give most of our degrees nowadays to hurdle-jumpers. The fault is more ours than theirs.

If a degree *means* anything, then let the nurse seek it if she wishes, but let her wait until it does mean something more than it means today. Far from thinking that the nurse is not worthy of a degree, I feel on the contrary that the bachelor's degree at its present value is not worthy of the nurse! The highest type of nurse stands in a position of such dignity and such proven worth that her sense of values should lift her eyes above

what Miss Kathleen Russell calls "the glamour of these symbols," and I agree with the ideas expressed by Miss Russell in her able article in the December, 1928, issue of *The Canadian Nurse*.

The plan which I now place before you is based largely on the Hart and Van Wart plans, together with some additions and modifications of my own. If the plan is good, give the credit to Miss Hart and Dr. Van Wart:—

I would suggest two courses. The first would extend over a period of three years of institutional training, followed by a supervised internship of six months in the field of private duty.

The first eight months would be spent in a university and would cover a pre-clinical course of twelve subjects, six in each term. The presentation of each subject would differ markedly from the usual presentation, and would be simplified, condensed, and particularly designed to serve the actual working needs and experiences of nursing practice. The subjects are as follows:—

1. Anatomy and Physiology.
2. Human and Medical Biology.
3. Bacteriology (including Asepsis) and Elementary Immunology.
4. Chemistry.
5. Dietetics, condensing nutritional theory and emphasizing the relation of diet to the cause and treatment of disease.
6. History of Nursing, including Professional Ethics.
7. Psychology and Mental Hygiene.
8. Hygiene and Public Health.
9. Materia Medica.
10. Sociology, including the social and economic aspects of disease.
11. English Composition and Public Speaking.
12. Introductory Lectures and Demonstrations in Nursing Practice.

(Post-script: There would be no course offered in house-maid's work!)

In all of these courses, the laboratory method should be stressed wherever possible, memory-cramming and spoon-feeding methods minimised, and the self-teaching powers of the student developed to their utmost.

At the end of her university year, and following a month's vacation, the student nurse would enter a two-year period of practical and clinical instruction in an approved hospital. At the end of this period she would take her six months' supervised internship in private duty, and upon its satisfactory completion she would be awarded her Diploma in Nursing.

The second or advanced course would consist of an additional year of work, taken partly in the university and partly in the working field of some special branch of nursing. It would give the holder of a nursing diploma an opportunity for advanced study in a specialised field, it would add to her experience something in the nature of a senior internship, and it would be a required course for all nurses entering the field of public health work.

There, in brief, is the suggestion. We claim for it the following advantages:

(1) It would emancipate the student nurse from the present congested and ill-adjusted system of concurrent theoretical instruction and ward-duty, and it would relieve the hospital of many of its training-school problems.

(2) It would bring nurse-training into conformity with proper and accepted methods of instruction in the basic sciences which underlie all medical practice and health conservation. I can assure you that the science departments of our universities know their business, and there is nothing haphazard or irregular about their methods of instruction. The student nurse would receive from them a training that was sound, useful, and of the highest standard.

(3) It would relieve the hospital of a large part of the financial burden of full-time instructors, and of many

problems of staff administration besides. A hospital is a busy, high-tension institution, and the maintenance of the training staff is not the least of its problems.

(4) The pre-clinical course would weed out all of the mentally incompetent and almost all of the personally unfit, and would send into the hospital only those students who had given ample evidence that they are of the stuff from which good nurses are made.

(5) It would be productive of more uniform standards of nursing education throughout the land, and it would unite the forces of the university and the hospital in the same co-operation which has already been so fruitful in the university medical schools.

There are five good reasons why such a move would be valuable. If you can give me five good arguments that will nullify those reasons, I will accept them humbly, for it is ever the part of the scientist to search for the defects as well as the virtues of his reasoning. I submit the plan for your consideration, and hope that it may merit a place in your discussions.

3. The Nurse and Health.

The most interesting and significant development of modern nursing is, to me, the increasing emphasis on the nurse as an invaluable agent for the conservation of health.

I make no invidious comparison between any of the branches of nursing. Each special field has its own importance, its own indispensable place, and as there is no branch of nursing with which I have *not* had some contact, either in my hospital years or in subsequent experience, I can not do other than accord to each branch the admiration and respect which it deserves.

But you have asked me to deal with nursing from the scientific viewpoint, and I am thereby constrained to view the matter biologically. Under the compulsion of biological fact, I have no other choice than to state with all

emphasis that the pre-eminent and commanding figure, the figure of the greatest social and scientific significance in the future of nursing, is that of the public health nurse.

Having every regard for scientific restraint of speech, and confident that I am making no exaggerated statement, I say that in the years to come the public health nurse will be potentially the greatest single instrument for the conservation of human health.

Let me place behind that statement a supporting background of the biological significance of disease, and the relation of health education to the physical destinies of mankind.

* * *

Disease is one of the strangest phenomena in Nature. While its effects are obvious, there are many of its causes that have yet to be explained. There is evidence that disease is of immense antiquity, and it is possible that it has been co-existent with the entire span of life throughout the ages. Certainly we have no evidence that primitive life was perfect and that later organisms fell from their high estate and made possible the development of disease as an evolutionary product. The field of parasitology alone asks questions which we can not answer, and immunology in its present state is unable to throw much light on the subject. Sometimes it would seem that disease has served a useful function in the economy of nature by destroying the unfit; at other times it has raged like a mad, unreasoning demon, destroying the fit and often leaving the unfit to survive. Let us not be too glib about the place of disease in biological history; we have still too much to learn.

But there is certain ground upon which we may stand with confidence. We know for a fact that most if not all disease is the result of some violation of natural law; the organism has failed to make the required responses to certain demands, and pen-

alty is thereby meted out to it according to the degree of its transgression. Among the lower animals these laws operate blindly and automatically.

But there is a different situation when we come to man, for there are three powers given to us which are greater than the lower forces of Nature and which enable us to wrest our fate from the hands of the blind god of chance and shape for ourselves a new and higher order of life on this planet.

Those three forces are Free-will, Knowledge, and that strangest and most inexplicable of all forces, whose very name is a synonym of Deity,—the power of Love.

Free-will, the liberator, that makes us not behavioristic puppets but children of God, endowed with the high privilege and charged with the solemn responsibility of choosing our own deeds and destinies.

Knowledge, that "mastery through service" for which science seeks, that man may look upon the world in which he lives with understanding, with spiritual insight, and with control over the forces of Nature through an obedience to the natural laws which govern those forces. By knowledge he will come to kingship over the forces of Nature, but he will only retain his crown as long as he respects and obeys the powers and demands of his subjects. If he fails to balance free-will with self-discipline, if he fails to balance scientific power with moral law, if he spends the resources of his kingdom foolishly, then his subjects, the forces of Nature, will rise up and depose him and destroy him.

Love, that mystic power which is performing the greatest miracle in all Nature,—the transmutation of the human spirit from brutality to gentleness, from self-interest to unselfishness, from race hatreds to world friendship, from Ypres where your brothers met the gas, and Etaples where your sister nurses were bombed, from the Lusitania with women and babies struggling in the black, icy

water, from these places of horror and madness and insane cruelty,—on to Geneva and to what, despite all difficulties and delays, must be the ultimate triumph of peace on earth, good-will to men.

"Something," says Fosdick, "has been at work here!" Yes, the same something that moved you, whether you knew it or not, to give your lives to shield and heal those who have fallen under the grim onslaughts of disease, and to work toward a day wherein disease, like war, must be prevented.

* * *

Here then are the three forces with which we are empowered to conquer disease.

What realisation grows out of them?

This: that we must abandon all fatalism, all laissez-faire, all shoulder-shrugging, all inertia, and to realise that we can conquer disease, or the greater part of it at least, if we *want* to. We don't *have* to go on indefinitely, making the same old blunders and receiving the same old penalties of pain. Mankind in the mass is slow to realise that, but the achievements of preventive medicine and public health are placing signboards on every roadway of life and pointing the way at last to physical safety. Even the obstructionist is beginning to know that it is his own interests that he is hurting, and presently he may even realise that he belongs in the same category as the village idiot who went around hitting himself on the head with a hammer because it felt so good when he stopped!

* * *

What is our chief instrument against disease?

Education. *Real* education; not half-hearted teaching and superficial smatterings, but a vigorous, adequate, life-long process which will enable us to meet successfully the demands of natural law, the demands of human society, and the demands of those spiritual ideals which alone can make

our physical life a thing of beauty and meaning and service.

Our present methods of health teaching are not adequate to meet the demands of biological law. Nature is not concerned with our theories or systems of education, and no curriculum that ignores her dictates can long endure.

Health teaching can not be entrusted to the inexpert or half-trained.* I feel that we are coming to a time when we must put the subject where it belongs: in the hands of a medically-trained person who will specialise in such work and who is able to carry it on with vigor and skill and efficiency.

Who is that person?

The public health school nurse of the future.

She will know her business, she will do the health teaching herself, and her work will result in a new and brilliant era of health conservation.

She will have a trained understanding of the many complex factors influencing health and disease. She will combine with her teaching the physical inspection which she is already performing so successfully in many schools, and she will extend her work from the school into the community (you can not separate them) and serve as a community health teacher of adult classes as well as in the school. She will serve the medical profession better than ever before, for she will act as an intermediary between the physician and the home and increase his power to serve the ideals of preventive medicine.

I ask you, therefore, to consider in your discussions the principle of the specific training of public health nurses for regular health-teaching duty in the schools. It is a plan that could be brought into immediate action in a few limited fields, for experiment and observation, and within a few years it could be extended over larger areas. I have the most earnest conviction that if you will try that experiment you will succeed, and you

(*See Survey Report, pp. 132 and 133.)

will thereby unite the power of our medical and educational institutions in bringing to pass at last an adequate educational programme of that knowledge of physiological and hygienic law which is demanded by Nature and by the safety and progress of our civilization.

I am very much in earnest about this. Although I am a scientist and intensely proud of the service that science has rendered to humanity, I must nevertheless confess that scientific knowledge alone can never shape life to a better form. The old copy-book phrase "Knowledge is power" is only a half-truth. Knowledge is only power when it is acted upon by the catalytic agent of a great ideal, its potential forces liberated, made kinetic, and harnessed into active service.

I in my bacteriological laboratory may make some small addition to science, but my fellow scientists and I are depending on the public health worker, the nurse, the doctor, and the educationist to translate into practical and effective *working* knowledge our discoveries in the field of human biology.

Yours is the greater task, and the harder one. We work in our laboratories, shielded from the world, supported in means and in spirit by our universities, and free to search out the truth.

But you must battle against social and economic and political difficulties, and the temper-trying resistance of the "fads and frills" type of obstructionist.

We work patiently, but you must have a different kind of patience.

We know when we arrive at truth, but you must convince the public and the legislator that it *is* the truth.

We must be the searchers.

But you, nurses of Canada, must be the teachers.

* * *

4. *The Nurse as a Woman.*

I have now done what you asked me to do. I am conscious of the faulty

way in which I have performed the task assigned to me. I wish that I could have done better.

What I have to say in closing is difficult to write down on paper, though I have been asked to do that. Will you allow me to conclude my address by speaking very informally,—not as a scientist to a nurses association, but as a man to a group of women. So I will take off my lab. coat, and you will take off your cap, and we will be "off duty" for a while, and I will try to say what I think of the nurse, not in her professional capacity, but just as a woman.

It was John Knox who said that "every scholar is something added to the riches of the commonwealth." I feel that every nurse who is worthy of the highest traditions of her calling (and there are not many who are not) is something added to the riches of Canadian womanhood.

The relation between your personal qualities as a woman and your professional duties and experiences as a nurse is a reciprocal relation,—you give something that can not be measured, you receive something that can not be described. Could I record that measure or make that description, I might be able to pay you a tribute in some degree worthy of what you are and what you have done.

But the glory of your profession can never be put into words, and even if that were possible, it would be hard to give them utterance. For it is not easy to speak of the things that we hold dearest in our life and work. Those things are better kept in some quiet room of remembrance, some hidden garden of the spirit, than to be spoken of before crowds.

But somehow I can not leave them altogether unsaid tonight. No one has ever in spoken word or on printed page, paid an adequate tribute to the nurse. Perhaps the fact that we are so inarticulate *is* a tribute. Wordiness is never the best praise, and all eulogy so easily verges upon mere hyperbole and grandiloquence. I think I like

best the simple words on a bronze plate in memory of a nurse who died in the war: "She did her duty."

The faithful performance of duty, wherever it may lie, is forever the sterling mark of real manhood and womanhood. There is no duty worth doing that is not difficult. And you who spend your lives in the presence of pain, you who look daily upon broken bodies and sometimes upon broken hearts, you have the most difficult duty of all. The simple statement that you have done *that* duty is praise beyond all the panegyrics of writers or orators.

For it is a duty that tests the uttermost worth of a woman, in bodily strength, in intelligence, in resourcefulness and self-reliance, in rigid self-discipline and professional bearing, and—greatest test of all—in her philosophy of life and her spiritual stamina.

* * *

Why did you enter nursing?

The very fact that you have deliberately chosen it as a life work is itself some evidence of your qualities and ideals.

You knew, in part at least, what was ahead of you.

There were easier things to do,—work that would give you greater comfort, greater freedom, greater safety, happier surroundings, better pay. Why did you choose this?

It was never the choice of self-interested women, shallow women, time-wasting women. It appeals only to one sort of woman,—the woman who sees before her a duty and an opportunity for service that challenges her to match the best that is in her against the difficulties that face all who would bring in a better order of human life. That is a task that calls only to strong men and women,—there is no place in it for the coward or the shirker.

Matthew Arnold said, "There is a power within us, *not ourselves*, that makes for righteousness." No greater discernment of the dual nature of human personality was ever written

into one sentence. Who turned your eyes toward the suffering of the world? Who moved you to lend your young strength to the weak? What hand came down and pointed you the way? And were there . . . nail-prints . . . on that hand?

* * *

What has been the effect of your nursing experience upon your philosophy of life?

Has it shown you the futility of life, or its glory?

You have looked upon the degradation of the flesh. But out of the welter of pain and physical wreckage have you not seen time and again the unconquerable spirit, the inviolable soul arise? You have looked upon tragedy, but on triumph too. You have seen the fool meet the rendered accounting of his folly, but you have seen too the saint smile in the face of Death. You have seen the coward sometimes, but the hero often, for there is no place on earth where one looks daily upon stark heroism as one does in a hospital.

You have seen the pitiful drama of little lives pass before your eyes, with their faint reflections of Bethlehem and their poor little Calvaries, and you knew that even with their faultiness and their limitations, they were trying somehow to follow Him—after their fashion.

And what wonderful men and women you knew among your working comrades! I remember a nurse whose life burned slowly out before our eyes. Her life was like a white candle burning before the altar of God. The candle burned down, but the light remains in the memory of all who knew her.

You too have seen lives that were so full of sweetness and strength and beauty that they seemed to bring sunlight and hope and the vision of what life at its best can be.

Did you look upon these things unmoved, unchanged?

I think not.

They say that the nurse needs a liberal education.

She has had it.

* * *

What is the hardest ordeal you have had to face, and what grows out of it?

(I do not want what I say here to be printed.)

* * *

And what is the reward of the nurse?

I saw one nurse meet with all the reward a real nurse could wish for. She was a splendid little soldier, that one. Clever as they make them, and utterly devoted to duty. A prim little thing, and oh! *very* professional. Absolutely imperturbable. She had read Osler's "*Aequanimitas*," and was bound she was going to live up to it.

There came a time when in an emergency she did a magnificent piece of work and did it under intense strain and difficulty, and with the greatest self-sacrifice. (I will not go into details.) We were all proud of her.

And the day after, when I was walking along the corridor with her, we met her doctor,—a man of few words, but the wisest and kindest and gentlest physician I ever knew,—and he stopped and laid his hand on her arm—I can still see his hand against her sleeve, a big brown hand with a big white scar on the back where a piece of shrapnel had gone through—and all he said to her was "Well done, daughter, well done!"

And the professional mask dropped and the tears came with a rush and the Oslerian *aequanimitas* blew clean up.

For words like that from a man like that are the best reward that a nurse like that can know.

* * *

So you have walked the pathway of a great experience, you have car-

ried yourselves well, and you have purified and enriched your womanhood with deeper sympathies and a higher sense of values.

And you have done your duty.

But still greater work lies ahead. The care of the sick is your first duty, but it is *not* your greatest opportunity for service. You must help us to build a new world from which preventable disease will be banished. It is a huge task, but what has been done proves what can and will be done.

It can not be done unless your profession shapes itself toward new fields of service, strengthens its personnel, improves its methods and increases its powers, and kindles in its heart a passionate determination to bring human life—physical and spiritual—to a higher level than ever before.

You will have hard battles to face, but they will be no harder than those the founders of your profession fought and won. You who have shown such courage and devotion and such a spirit of progress in your work, you will fight and you will win.

For you will not fight alone. He who has walked unseen beside you down the long corridors of pain where the red lights burn above the doorways, He who has stood beside you in the sick-room and watched the tenderness of your ministry, He will be with you, even unto the end.

God bless you, brave gentlewomen, and give you strength and wisdom and courage for the duty which still lies before you, and when you have done that duty, and the days of your service are ended and the long shadows are falling, there shall come to you the Physician whose orders you carried out so faithfully, and He will lay His hand on your arm,—a scarred hand, too,—and say "Well done, daughter, well done."

The International Council of Nurses

A BRIEF HISTORICAL SKETCH

At the Annual Conference of the Matrons' Council of Great Britain and Ireland, 1899, Mrs. Bedford Fenwick proposed the formation of an International Council of Nurses. Speaking briefly on the "International Idea," Mrs. Fenwick said, in part:

"I desire to bring before this meeting a question which I believe to be of international interest and importance, and I am happy in knowing that it will be supported by a speaker whose eloquence has few equals, and, perhaps, no superiors. I will speak only from the point of view of the trained nurse; Mrs. May Wright Sewall will with greater force discuss the question from the wider point of view of its public usefulness. The nursing profession, above all things at present, requires organisation; nurses, above all other things at present, require to be united. The value of their work to the sick is acknowledged at the present day by the government of this and of all other civilised countries, but it depends upon nurses individually and collectively to make their work of the utmost possible usefulness to the sick, and this can only be accomplished if their education is based on such broad lines that the term 'a trained nurse' shall be equivalent to that of a person who has received such an efficient training, and has proved to be also so trustworthy, that the responsible duties which she must undertake may be performed to the utmost benefit of those entrusted to her charge. To secure these results, two things are essential: that there should be recognised systems of nursing education and of control over the nursing profession. The experience of the past has proved that these results can never be obtained by any profession unless it is united in its demands for the necessary reform, and by union alone can the necessary strength be obtained. This union has been commenced in this country and in the United States.

It remains for the nurses of other lands to follow our example and unite amongst themselves; but I venture to contend that the work of nursing is one of humanity all the world over, and it is one, therefore, which appeals to women of every land without distinction of class or degree or nationality. If the poet's dream of the brotherhood of man is ever to be fulfilled, surely a sisterhood of nurses is an international idea, and one in which the women of all nations, therefore, could be asked and expected to join. The work in which nurses are engaged in other countries is precisely the same as that in our own. The principles of organisation would be the same in every country, the need for nursing progress is the same for every people, and my suggestion briefly is, therefore, that we should here and today inaugurate an International Council of Nurses, a body like the International Council of Women, composed of representatives of the nursing councils of every country, a body which shall in the first place help to build up nurses' councils in those countries which do not now possess any nursing organisation at all, which shall afford to those countries the information acquired in England and America in the progress and development of our work, aiding them with our experience, helping them to avoid the difficulties which we have met.

"I beg, therefore, to propose:

"That steps be taken to organise an International Council of Nurses!"

Then a Provisional International Committee was formed to proceed with the necessary steps in putting into effect organisation of an International Council of Nurses. Countries represented on this committee were Great Britain, the United States, New Zealand, New South Wales, Victoria, Holland and Canada (Miss M. A. Snively and Miss Murray); also Mrs.

Gordon Norrie, Denmark, and Sister Henrietta of Cape Colony—at that time the Matrons' Council had no honorary member resident in these two latter countries.

In 1900, the Provisional Committee met in London, when a constitution was adopted and officers elected. Mrs. Fenwick was elected President, an office which she held until 1904, when she was made the Honorary President. Miss L. L. Dock (U.S.A.) became Honorary Secretary, and Miss M. A. Snively (Canada) Honorary Treasurer.

The first Congress of the Council was held in Buffalo, New York, in September, 1901, during the Pan-American Exposition. Following an address by Mrs. Fenwick on The Organisation and Registration of Trained Nurses, the delegates assembled expressed the opinion that:

Whereas the nursing of the sick is a matter closely affecting all classes of the community in every land;

Whereas to be efficient workers, nurses should be carefully educated in the important duties which are now allotted to them;

Whereas at the present time there is no generally accepted term or standard of training, nor system of education, nor examination for nurses in any country;

Whereas there is no method, except in South Africa, of enabling the public to discriminate easily between trained nurses and ignorant persons who assume that title; and

Whereas this is a fruitful source of injury to the sick and of discredit to the nursing profession:

It is the opinion of this International Congress of Nurses, in general meeting assembled, that it is the duty of the nursing profession of every country to work for suitable legislative enactment regulating the education of nurses and protecting of the interests of the public, by securing State examination and public registration, with the proper penalties for enforcing the same.

The first quinquennial meeting of the Council was held in Berlin (Germany) in 1904—at which time Miss Margaret Breay was elected Honorary Treasurer, an office which she held continuously until 1925. The next international gathering, an Interim Conference, took place in Paris, June, 1907, where, with the aid of Mlle. Chaptal, a most successful conference was held. The second quinquennial meeting was held in London in July, 1909, when for the first time in history nurses from fifteen countries met together. Canada was received into affiliation at this meeting, and during a visit to Windsor Castle and the Royal Domain, with royal consent, Miss M. A. Snively for the Canadian delegation placed a beautiful wreath at the foot of the exquisite marble tomb of the late Queen Victoria at Frogmore. Before leaving Windsor, a telegram was sent to the Lord Chamberlain, conveying the loyal gratitude of the Canadian National Association of Trained Nurses for the honourable privilege granted its members by His Majesty King Edward VII. A photograph of the wreath and a copy of the illuminated address to King Edward are treasured among the archives at the National Office at Winnipeg.

Cologne, Germany, was the meeting place for the third regular gathering of the Council, in 1912, with Sister Agnes Karll presiding. At this time there was unanimous agreement that the council should undertake to establish an appropriate memorial to Miss Florence Nightingale.

Plans for a meeting scheduled for 1915 in San Francisco were cancelled owing to disturbed conditions which were world wide. Decision was made to arrange for a meeting of the Council in Copenhagen in 1918, but this too had to be withdrawn. However, a number of members of the Executive Committee of the I.C.N. conferred together at Atlanta in April, 1920, and eventually, in 1922, a meeting of the Grand Council took place

in Copenhagen. Then, in 1925, a Congress was convened in Helsingfors and a Canadian delegation of over fifty nurses extended a cordial invitation for the next Congress to be held in Canada. However, the majority favoured an invitation from China. At an Interim Conference in July, 1927, when it was announced that the Nurses Association of China doubted being able to proceed with arrangements owing to the unsettled national conditions, the Canadian Nurses Association was privileged to extend an invitation for the Congress of 1929. Decision of place of meeting was left to the Board of Directors, who chose the city of Montreal.

The majority of Canadian nurses recall with pleasure the thrill of anticipation experienced as nurses throughout the Dominion undertook preparations for the C.N.A. to be hostess to the I.C.N., and now the

nurses of France and Belgium are proceeding with their arrangements for the next Congress, which will be held in Paris, July 10th, 11th and 12th, and in Brussels the 14th and 15th, 1933.

At the Congress in Helsingfors, Miss Christiane Reimann was appointed full-time Secretary, and later International Headquarters were opened in Geneva. The I.C.N., which in 1908 had only three national organisations in affiliation, now has twenty-three, representing in January, 1931, a membership of about 160,000, one of the largest, if not the largest, professional organised international bodies in the world. Since January 1926, there has been published an international nursing journal, first called *The I.C.N.* and now *The International Nursing Review*.

(Reference: History of the International Council of Nurses, 1899-1925, by Mrs. Bedford Fenwick and Miss Margaret Brey.)

Nightingale Week

NOTE: Readers of this *Journal* are referred to *The British Journal of Nursing*, May, 1932. The reprint of an editorial in the same issue is published herewith. Miss Grace M. Fairley, Superintendent of Nurses, Vancouver General Hospital, Vancouver, B.C., and Chairman of the Nursing Education Section, Canadian Nurses Association, represented the President of the C.N.A. during Nightingale Week in London.

"The Executive Committee of the National Council of Nurses of Great Britain at its recent meeting on April 14th received a report of the negotiations between its three representatives, the President, Mrs. Bedford Fenwick, Miss A. Lloyd Still, and Miss E. M. Musson, which had resulted in harmonious agreement between the International Council of Nurses and the League of Red Cross Societies, who together had drafted The Florence Nightingale International Foundation Scheme, which it was hoped would meet with the approval of the National Organisa-

tions of Nurses and of Red Cross Societies. It is satisfactory to report that an explanatory letter, together with a copy of the Draft Scheme, has already been sent around the world from Headquarters at Geneva, signed by the International President, Mlle. Chaptal; Mrs. Bedford Fenwick, Chairman of the Florence Nightingale Memorial Committee of the I.C.N., and by the Secretary, Miss C. Reimann.

"Our Executive Committee decided to organise a 'Nightingale Week' from July 4th to 9th, and to invite as guests of our National Council the

officers of the I.C.N. and members of its Memorial Committee. These invitations have also been issued, and we very earnestly hope that we may have the pleasure of welcoming many international guests, so that they may consult with us on details of the practical organisation of the Florence Nightingale Foundation — without which interest and help we cannot hope for success.

"We are glad to report that Mlle. Chaptal, President of the International Council of Nurses, has accepted an invitation to be present.

"It is contemplated that the Florence Nightingale International Foundation should be an autonomous body constituted under English law, and governed by a Grand Council comprising five representatives of the League of Red Cross Societies, and two representatives of the National Florence Nightingale Memorial Committee of each participating country. The Grand Council will be responsible for the policy of the Foundation, and between its meetings will delegate its powers to a Committee of Management, elected by the Council. It is suggested that the Committee of Management should comprise three representatives of the International Council of Nurses, three representatives of the League of Red Cross Societies, two representatives of the National Council of Nurses of Great Britain, two representatives of the British Red Cross Society, one representative of Bedford College and one representative of the College of Nursing.

"The organisation of 'Nightingale Week' will be placed for early discussion on the Agenda of the Special Meeting of our Grand Council on

May 28th, so we hope for many happy suggestions and offers of hospitality. So far the suggestions approved are a Conference on the Constitution of the Draft Scheme and to arouse personal interest in Nightingale cult, by the inauguration of the Foundation at St. Thomas's Hospital, to which is attached the Nightingale Training School for Nurses—where so many unique relics of Miss Nightingale are preserved.

"To attend the Ceremonies and Presentation of Certificates to International Students at Bedford College for Women.

"To visit the Students' Residential Home at 15 Manchester Square, which is so happily conducted.

"To visit our National Council Headquarters, where again a very valuable History Section contains many items of Nightingale interest.

"To see the educational work of the College of Nursing—which takes part in the International Students' curriculum.

"To visit the 'House Beautiful' of the Royal British Nurses' Association—the first organisation of trained nurses in the world.

"To pay a visit of homage to the grave of Miss Nightingale at East Wellow, and, by kind permission of Mr. J. J. Crosfield, to see Embley Park, that lovely home of Florence Nightingale's girlhood.

"And generally to entertain, instruct and interest our colleagues from near and far, in a personality of unique genius and greatness, whose association with nursing sheds such a glow of beneficence upon us—for which we can never be sufficiently grateful."

Interchange of Teachers throughout the Empire

By HELEN COWIE, M.A., Glebe Collegiate Institute, Ottawa, Ont.

Many of you are, no doubt, familiar with the work of the League of the Empire. Some of you may have enjoyed its hospitality at some time at 124 Belgrave Road, Westminster, and know that a part of its practical work is to promote co-operation between the different countries and colonies of the Empire, especially in affairs connected with education. It was by the League of the Empire that the scheme for the interchange of teachers and inspectors throughout the Empire was initiated in 1907 and has been carried on since. Exchanges were made spasmodically before the war, but since the war the movement has gathered fresh life and vigor. Since 1919 over 1,500 teachers have moved in exchange. The greatest number, of course, of these exchanges have been between the far away parts of the Empire and the Mother Country, the London County Council alone being willing to accept fifty teachers a year from abroad. The majority of the teachers have been elementary school teachers, some secondary and a few inspectors.

The movement has had its vicissitudes and has met many obstacles, the latter chiefly connected with the fear on the part of authorities of too great dislocation of their system; at the present time, however, the arrangements are considered very adequate and satisfactory to all concerned. They are as follows: Teachers receive what is tantamount to one year's leave of absence with pay—their rank and opportunities for promotion are supposed to be safeguarded during their absence. So, when the writer was in England, the salary was paid by the Board of the Ottawa Collegiate Institute, deduction for superannuation made, and Miss ——— from London acted, as it

were, as substitute. Travelling expenses are borne entirely by the teachers exchanging. As a rule a period of six months is required to examine qualifications, locate teachers and complete the arrangements. The scheme has ceased to be regarded as experimental and by virtue of its own success is now a definite contribution to Imperial education. Certainly teachers return satisfied with their experiences, some enthusiastic, and one does not hear much complaint from the authorities that schools suffer from the presence of an exchange teacher.

Of the advantage and the gain to the teachers professionally, there can be no doubt. Their interchange provides opportunity for teaching under totally different systems from their own for handling a very different type of child and living under other conditions and surroundings. For teachers visiting Britain, many educational advantages are offered and programmes are arranged to interesting and historic places. Each year a certain number of overseas teachers are invited to the Royal Garden Parties at Buckingham Palace and on special state occasions are granted privileges. Obviously then, one of the features of the exchange must be the enlargement of personal opportunity and experience, not to mention the gain of the mental stimulus from the freshness and novelty of a new adventure. The scheme involves hard and unselfish work on the part of several enthusiastic people in London and elsewhere, whose only reward lies in the hope that thus the interests of Empire may be served, that there may result a spreading of the knowledge and ideals of all parts of the Empire, a breaking down of those factors which lead to disunity, namely, a distrust of others arising out of ignorance of their mental outlook, a strengthening of these bonds so

(A paper read at the Nursing Education Section, Registered Nurses Association of Ontario Annual Meeting, March 31, April 1, 2, 1932.)

fragile and yet potentially so strong, which bind the vast Empire together. This places somewhat of a responsibility on those who have benefited by the scheme. The hope is expressed that in some faint way they are doing their bit.

While the advantages are predominantly great, no scheme could be so perfect as to have *no* disadvantages and one great disadvantage is connected with the commodity our spirit would fain despise and cannot—"money." Now, remuneration for the service of teaching is not by any means uniform in all parts of the Empire nor is the cost of living and one gains or loses financially accordingly. For instance, this year Scottish and English teachers on exchange in Canada must have suffered somewhat from the depreciation of the pound, while Canadians in England are probably able to have an almost luxurious time as a result of the superior value of the dollar. The fact that in crowded European cities one

may be called upon to meet social and industrial conditions of a nature depressing beyond anything to be encountered in a newer country and that consequently one's work may lie in uncongenial and unfamiliar surroundings constitutes to certain types of mind, a source of personal unhappiness and discomfort. But, then, one must certainly postulate that only those of some adaptability and flexibility of mind attempt to exchange; an open, tolerant and sympathetic mind must be a sheer necessity if the exchange is to be a success.

After having spent a year as an exchange teacher in a secondary school in London, the writer cannot think of any disadvantages suffered; on the contrary, the year was so full of pleasure and profit and of rich professional contact, that it must always be regarded as a year of exceeding great privilege and opportunity.

Canadian Public Health Association

By BERTHA E. JOHNSON, Department of Health for Ontario

The annual meetings of the Canadian Public Health Association and the Ontario Health Officers' Association were held jointly at the Royal York Hotel, May 25-27, when the former celebrated its "coming of age".

The programme was arranged to permit of the sectional meetings being held in the morning, and the general meetings in the afternoon. The opening meeting on Wednesday morning, under the auspices of the Ontario Health Officers' Association, dealt with technical matters, of interest to the Health Officers. In the afternoon, Dr. Louis I. Dublin, President, American Public Health Association, presented an address on "Public Health and the Economic Depression". He drew attention to the fact that health budgets were being drastically cut, and as a result of a survey he had found that Public Health Nursing and Child Hygiene were two that were being sacrificed. In his opinion, this was unwise. The tuberculosis budget was not cut, because the workers, through their educational efforts, had awakened the public conscience to the need of that activity. He advised those

charged with administering reduced budgets to follow a policy of careful planning, considering first the health needs of their people.

Dr. C. M. Hincks discussed the growth of the Mental Hygiene movement, emphasizing the improvement in the care of the insane and the increased interest in the prevention of mental illness that had taken place in twenty years. He stressed the importance of preparation of all health workers along mental hygiene lines.

In his paper on "Maternal Mortality" Dr. Van Wyck brought out the need for better training in obstetrics for medical students and an increased conservativeness on the part of the physician.

Miss Laura Gamble, formerly director of Cattaraugus County Health Demonstration, presented a picture of generalised Public Health Nursing and its possibilities in bringing the services of the organisation the nurse represented, to the people, as well as interpreting to them the policies of her department. The point was made that bedside care was

frequently the best means of gaining the confidence of a rural community.

In discussing heart disease in adult life, Dr. John A. Oille stated recent research had shown that rheumatic fever has a mild degree of infectivity, but only in children under fifteen years does rheumatic fever affect the heart.

At the dinner tendered by the Province of Ontario and the City of Toronto, His Worship Mayor Stewart welcomed the Associations to Toronto. The guest speaker of the evening was Hon. Dr. R. J. Manion, who was introduced by Hon. Dr. J. M. Robb, Minister of Health.

The meeting of most interest to the readers of *The Canadian Nurse* was the Public Health Nursing Section. The Chairman, Miss Nora Moore, of Toronto Department of Health, presided.

Miss M. L. Moag gave a comprehensive review of the chapter on Public Health Nursing in Dr. Weir's "Survey of Nursing Education in Canada".

Under the caption of "How the Psychiatrist looks at Public Health Nursing," Dr. W. T. B. Mitchell, Director, Mental Hygiene Institute, Montreal, pointed out the strong and weak points of the Public Health Nurse in her approach to family and individual problems.

Public Health Nursing was next viewed by a private physician, Dr. A. M. Jeffrey, who, at one time, was on the staff of a city health department. In his constructive criticism Dr. Jeffrey considered a situation where a staff of public health nurses served the community, and their group psychology was contrasted with the individualistic point of view of the private physician. He suggested that this was the basis of much misunderstanding between two workers who should have similar objectives. It was his opinion that the nurse sometimes, in her enthusiasm, exceeded her limitations, but the physician also failed at times to recognise her motive in so doing.

Mrs. Plumptre assumed the role of a private citizen and ratepayer, in "Looking at Public Health Nursing". She asked for a definition of Public Health Nursing, and urged upon the group that they interpret their activities to the public more persistently and more definitely. The man on the street is concerned with the cost of all municipal undertakings, and Mrs. Plumptre emphasized the importance of showing the cost of sickness as contrasted with the expenditure for the promotion of health.

"How the Public Health Nurse Looks at Herself" was the part of the symposium dealt with by Miss B. E. Harris, of Oshawa, Ont., who pointed out that while the work of the Public Health Nurse was arduous, it brought as its reward the satisfaction of service to mankind.

The officers of the Public Health Section, Canadian Public Health Association, elected for the following year are: Chairman, Miss H. Dykeman, Director of Public Health Nursing, New Brunswick Department of Health, Saint John; Vice-Chairman, Miss Edith Fenton, Director, Dalhousie University Clinic, Halifax, N.S.; Secretary, Miss Mona Wilson, Director, Public Health Nursing, Prince Edward Island Department of Health, Charlottetown.

The meeting which brought the convention to a close was addressed by Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare, Manitoba, who read a paper on Tuberculosis prepared by Dr. David A. Stewart, who was unable to be present. This paper described the facilities for the control and prevention of tuberculosis in that province. A Travelling Clinic serves the province remarkably well, bringing examination and diagnosis within reach of all. To a considerable extent this service is financed by the Christmas Seal sale funds.

Dr. Haven Emerson, Columbia University, spoke on the vital subject of "Public Health and Public Welfare". In his clear, concise manner he presented the subject on the basis of fixing the responsibility for the health and the welfare of any people on those prepared by education and experience, rightfully to assume it. In the care of the sick the hospitals must be under medical jurisdiction, and in the realm of disease control and prevention the same authority should be recognised, while in the sphere of social mal-adjustment, the diagnosis should be made and treatment prescribed by those competent in that field—the professional social worker.

The officers for the coming year are: Honorary President, Dr. G. I. Taylor, Minister of Health, New Brunswick; President, Dr. Wm. Warwick, Deputy Minister of Health, New Brunswick; Vice-President, Dr. Alphonse Lessard, Quebec, Dr. M. R. Bow, Edmonton, Dr. F. W. Jackson, Winnipeg; General Secretary, Dr. J. T. Phair, Toronto; Treasurer, Dr. C. P. Fenwick, Toronto.

Many of the papers presented will be published in the coming numbers of the *Canadian Public Health Journal*.—B.E.J.

GRADUATE NURSES' ASSOCIATION OF BRITISH COLUMBIA (Incorporated 1918)

An Examination for title and certificate of Registered Nurse of British Columbia will be held September 14th, 15th and 16th, 1932.

Names of candidates for this Examination must be in the office of the Registrar not later than August 13th, 1932.

Full particulars may be obtained from:

HELEN RANDAL, R.N., Registrar, 516 Vancouver Block, Vancouver, B.C.

News Notes

ALBERTA

LAMONT: Mr. and Mrs. William Turnbull were tendered a reception and shower at the home of the Misses Tedford, at Edmonton, on Friday, June 10th. Many friends from in and out of town were present. The bride and groom were the recipients of many beautiful and useful gifts, expressing the kindly wishes and high esteem of their numerous friends. Mrs. Turnbull (Mina Phillips, Lamont General Hospital, 1929) has been doing remarkable work in the community in which she has been serving as Provincial District Nurse, in organising sewing circles and relief work, as well as song services and other endeavours to aid the people to maintain their morale while passing through such very trying times. In this she has the whole-hearted sympathy and co-operation of her husband. Upon their return to Winfield they will resume their social work in the West country, where the heavy hail-storms of last year have caused such distress. They take with them the well wishes and prayers of a host of friends.

BRITISH COLUMBIA

GENERAL HOSPITAL, VANCOUVER: The regular monthly meeting of the Alumnae Association was held in the Auditorium when members were privileged to bring a friend. The speaker of the evening was Mrs. Laura Jamieson, who gave the last of a series of talks on present-day conditions in other countries. One hundred dollars a month donation from the Alumnae to the Hospital was decided on to assist with the unemployment situation among the graduates and to provide special attention for the sick indigent patients who are seriously ill. The nurses have arranged to hold a series of private parties to raise money for this fund. These affairs are proving most enjoyable in furthering the social side of the Alumnae activities as well as the financial. New plans are on foot to organise a shopping project whereby a discount will be given by numerous Vancouver shops to purchasers among the members and this discount payable to the Relief Fund. A very active President and Committee are striving hard to help meet the need of the Alumnae members less fortunate.

Meetings will not be held throughout the summer months.

Alumnae members learned with regret of the death of Mrs. Harold Findlay, formerly Florence Shindler (1919). Previous to her marriage, she had been assistant matron at the Infants Hospital and charge nurse on the Children's Ward, Vancouver General Hospital. Mrs. Findlay was awarded the Dr. Covernton Scholarship in Pediatric Nursing in 1919.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario, in July, 1932, were 959. Fourteen less than in June, 1932.

APPOINTMENTS

Miss Helen Miller, of the Victorian Order of Nurses of Canada, has been transferred from Sudbury to the staff at Woodstock, Ont.

Miss Eudora Watson (Toronto General Hospital, 1923), formerly in charge of the Red Cross Hospital at New Liskeard, has been transferred to Dryden, Ont.

Winnifred Griffin (Toronto General Hospital, 1925) has accepted a position in the office of the Central Registry, Toronto.

DISTRICT 1

The regular meeting of R.N.A.O. District Number One was held Saturday, May 28th, at the Town Hall, Strathroy, with Miss Priscilla Campbell, Chairman, presiding. Interesting reports from the annual meeting in Ottawa were given. The membership of R.N.A.O. in District Number One has increased to about 275 members (1931 membership was 200). Very interesting and instructive lectures were given in Thyroid Surgery and Eugenics by Dr. F. G. McFadden and Dr. McDougall respectively. Miss Mary Malloch, of London, was chosen as delegate to the Canadian Nurses Association meeting in Saint John. Following the adjournment refreshments were served by the courtesy of Strathroy Nurses' Alumnae, after which many visited the Strathroy General Hospital. The next regular meeting will be held in London, September 24th. A refresher course in Prenatal work has been arranged for September 22nd and 23rd at the Public Health Institute.

PUBLIC GENERAL HOSPITAL, CHATHAM: The graduation exercises proved a very attractive feature this year on the lawn of the Nurses' Residence, followed by a reception, tea and dance. The staff of the Hospital enjoyed their annual picnic on June 28th at Erie Beach.

At the June meeting of Chatham General Hospital Alumnae Association, Miss Winnifred Weir, who had acted as delegate to the meeting of District 1, held in Strathroy on May 28th, presented a very interesting report of the meeting.

DISTRICT 2

A meeting of District No. 2 was held in the Owen Sound General and Marine Hospital on June 15th with about fifty nurses in attendance. A hearty welcome was extended the visitors by Mrs. D. J. McMillan, President of the Owen Sound Alumnae. The main feature of the meeting was the very complete report of the Provincial meeting in Ottawa, which was given by Miss S. M. Jamieson of Brampton. Mrs. Waugh and Miss Harley gave a very enjoyable musical programme, after which supper was served. The autumn meeting will be held in Woodstock.

OWEN SOUND: The graduation exercises of the Owen Sound General and Marine Hospital were held May 31st in the City Hall, eleven nurses graduating. Mr. J. McLinden, president of the Board of Trustees of the Hospital, presided at the ceremonies. A much-appreciated address was given by Dr. H. Holmes, following which was the address to the graduating class by Rev. Elmer Kenny. The Florence Nightingale pledge was taken, led by Rev. E. W. Jewitt. Diplomas were presented to the nurses by Miss B. Hall, superintendent of the hospital, and Dr. G. H. Murray presented the pins. Miss Mae Simpson won the prize for general proficiency. Miss Marjorie Cruickshank won the prize for operating room technique, and Miss Margaret McKinley the prize for obstetrical nursing. A reception and dance for the nurses and their friends followed at the close of the Exercises.

Deepest sympathy is extended to Miss E. Webster, of Owen Sound, in the loss of her sister.

SIMCOE: Miss Marjorie Buck, superintendent, Norfolk County Hospital, and Miss Ann Lang, attended the C.N.A. convention in Saint John, N.B.

GENERAL HOSPITAL, BRANTFORD: The annual meeting of the Alumnae Association was held in the Nurses' Residence, Tuesday, June 7, 1932. Miss A. Hardisty presided, and after the routine business was disposed of, the election of officers for 1932-1933 took place. The 1932 Graduating Class was present and a social hour was enjoyed at the close of the meeting. The officers elected are as follows: Honorary President, Miss E. M. McKee; President, Miss K. Charnley; Vice-President, Miss G. Turnbull; Secretary, Miss H. D. Muir; Assistant Secretary, Miss V. Buckwell; Treasurer, Miss L. Gillespie; Social Convener, Mrs. D. A. Morrison; Flower Committee, Miss F. Stewart and Mrs. E. Claridge; Gift Committee, Miss W. Laird and Mrs. G. Andrews; The Canadian Nurse and Press Representative, Miss D. Arnold; Chairman Private Duty Council, Miss E. M. Jones; Representative to Local Council of Women, Mrs. R. Hamilton.

Miss E. M. McKee, superintendent, Brantford General Hospital, and Miss Grace Turnbull, Ontario School for the Blind, Brantford, motored to the C.N.A. meeting in Saint John. Miss Mary Meggitt (1929) is on an extended trip through the Canadian West and down the Pacific Coast to Los Angeles, California. Mrs. Claridge (1931) is supervising in the Brantford General Hospital during the illness of Miss Theresa Dawson. Miss Beatrice MacDonald (1930) is relieving Miss Gladys Westbrook during July and August. Miss Florence Westbrook (1922), of the University Hospital, Ann Arbor, Michigan, is spending her vacation in Brantford. Miss Colvin, Crile Clinic, Cleveland, Miss E. Bunn, Ulswater, Ont., Miss Valentine, Lakewood Hospital, Lakewood, Ohio, Miss G. VanEvery, Princeton, Miss

G. Westbrook and Miss A. Hardisty of Brantford, had a happy reunion at the home of Mrs. A. A. Mathews, 1923 class.

Miss S. A. Livett is spending her vacation in Galt. Miss Florence Stewart, night supervisor, is spending the month of July at Lake Seugog, Kawartha Lake District. Miss C. E. Jackson, Director of Nurse Education, is holidaying at St. Margaret, Laurentian Mountains. Miss Helen Murison, dietitian, is spending her vacation at Lake Seugog. Miss Jessie M. Wilson, assistant superintendent, is visiting Mrs. J. MacDonald (Ethel Collyer, 1922), Marion, Indiana. Dr. and Mrs. D. A. Morrison (Carmen McMaster, 1914) sailed recently for the British Isles.

WOODSTOCK: The annual meeting of the Nurses' Alumnae Association was held June 6th in the Nurses' Residence. Reports by the secretary and treasurer were read and approved. It was decided that a temporary reduction be made in nurses' fees, effective after July 1st. Officers were elected for the following year: Honorary Presidents, Miss F. Sharpe and Miss H. Potts, superintendent; President, Miss G. Jefferson; Vice-President, Miss M. Costello; Secretary, Miss L. Jackson; Assistant Secretary, Miss J. Kelly; Treasurer, Miss E. Eby; Press Correspondent and Representative to The Canadian Nurse, Miss D. Craig; Programme Convener, Miss H. Cook; Social Convener, Miss E. Hastings; Convener of Flower and Gift Committee, Miss E. Richard. Miss M. Davison gave a most interesting report of the R.N.A.O. convention held in Ottawa. Tea was served and a social half-hour closed the meeting.

The Alumnae Association entertained the graduating class at an informal dance held June 10th. The guests were received by Miss H. Potts, superintendent, Mrs. Shaw, president of Women's Hospital Auxiliary, and Mrs. Shedden, member of the Alumnae.

On June 24th the members of the Alumnae Association and their friends held a most enjoyable picnic at Southside Park.

Miss Helen Potts, superintendent, Woodstock General Hospital, attended the C.N.A. convention held at Saint John, N.B.

Miss Hazel Dennis is relieving Miss Eby, Public Health Nurse, during the month of July.

DISTRICT 4

The regular quarterly meeting of District No. 4, Registered Nurses Association of Ontario, was held at the Refectory in Niagara Falls on Saturday afternoon, June 18, 1932, Miss A. Wright presiding. At the annual meeting in Ottawa, it was decided to carry on with the Permanent Education Fund even if some sections could not make complete returns in five years, so Miss McIntosh, as convener, asked for a personal canvass in an endeavour to make allocation for District 4. Dr. Weir's report was discussed in brief papers by Miss E. Chisholm on Nursing Education; Miss E. Moran, Private Duty; and Miss A. Boyd, Public Health.

As the guests of the 'Nurses' Alumnae of Niagara Falls everyone enjoyed a picnic supper in the park and a delightful drive along the Niagara River.

HAMILTON: The forty-second graduation exercises of the Hamilton General Hospital School of Nursing were held on June 2nd in the Hospital Grounds. R. G. Wells, chairman of the Board of Governors, presided, and the address to the graduating class was given by Dr. J. K. McGregor, Chief of Staff. The programme was opened with the invocation, pronounced by Rev. W. E. White, and followed by the Florence Nightingale pledge, administered by Miss E. C. Rayside, Superintendent of Nurses. The Minister of Welfare, the Hon. H. W. Martin, was the guest speaker, and the large crowd gathered was charmed by his appealing and eloquent address. The graduating nurses were the guests of honour at a dance during the evening at the Nurses' Residence.

The following nurses have successfully completed the Public Health Course at the University of Toronto: Christine Livingston, Eva Bennett, Emily Dickie and Jennie Hoogendyke.

DISTRICT 5

A general meeting of District 5, R.N.A.O., was held at the Royal York Hotel, Toronto, on May 21, 1932. The afternoon session, beginning at four o'clock, discussed regular business, and Miss Beamish, Chairman, as representative of the district to the annual meeting of the R.N.A.O. held at Ottawa, presented a report of the sessions and social functions. In the absence of Miss Greenwood, Miss Mable Sharpe presented the report of the Permanent Education Fund. As the district had not met its objective for 1931, the committee asked for suggestions for raising the money. A motion was made "that a larger committee be formed and a system of canvassing be organised in order to reach each member personally in an appeal for funds".

Miss Millman, President of the R.N.A.O., stated reasons and advisability for organising section groups within the district, which plan had been under discussion for some time. Miss Edge, of the Private Duty Section, addressed the meeting, and Miss Isabel MacIntosh, of Hamilton, presented an abstract on the Private Duty Chapter of the Survey Report.

Miss Edna Moore, who has returned to Toronto from New York, as Director of Public Health Nursing for the Province of Ontario, read her paper dealing with the Public Health Chapter of the Survey Report, which had been received with so much interest in Ottawa. At the close of this session the Public Health members, under the chairmanship of Miss Vera Allen, V.O.N., elected their officers as an organised group. A dinner meeting was held in the roof garden at seventy-three, when about 120 members were present. The speakers were Miss Jean Browne and Dr. E. M. Best, of the Y.M.C.A. Miss

Browne outlined briefly Dr. Weir's report on the Survey. Dr. Best spoke of the qualifications of the individual that society was looking for today. Professional Education was essentially the spirit of the evening. Votes of thanks were extended to each speaker, and the members felt they had spent a profitable as well as pleasant half-day.

GENERAL HOSPITAL, TORONTO: Miss Ella Ratz (1921), who has been for two years in California, is at her home in Toronto. Miss Helen Silvers and Miss Jean Connell (1928), who have spent the past two years in Bermuda, have returned home. Miss Beatrice Foex (1931) has been awarded the Crowe Scholarship for further University study. Miss Foex will enroll in the Hospital Administration Course at the University of Toronto this fall. Miss Mae Caudwell (1927), who studied at the University of Toronto last year, has rejoined the staff of the Toronto General Hospital for the summer in charge of the Burnside obstetrical department. Misses Gunn, K. Russell, Jean Browne and Nettie Fidler attended the C.N.A. meeting at Saint John. Miss Rae Shipman (1922), who is engaged with Victorian Order of Nurses in Edmonton, spent two months among friends at her home in Ottawa and at Toronto. Miss Catherine McGibbon (1908), who has been ill for some time, has left to visit her brother in California.

WOMEN'S COLLEGE HOSPITAL, TORONTO: Miss Dorothy Bradford, a graduate of St. John's Hospital, Toronto, who is working in an Anglican Mission Hospital in Aklavik, addressed the Alumnae spring meeting. Miss Bradford gave a very vivid life picture of life amongst the Indian and Eskimo.

The graduation exercises of the School of Nursing were held at the Roof Garden of the Royal York Hotel on May 31st. Rev. Dr. Slater read the prayers before Miss Meiklejohn, superintendent, gave her very interesting report. The speaker of the evening, Mrs. Kirkwood, took as her subject that most appropriate topic, "Careers for Women".

Dr. Stewart gave a kindly message from the medical staff; this is always so much appreciated. Mrs. Plumptre spoke in glowing terms of the Superintendent's splendid service overseas, and in her gracious manner presented pins and diplomas to those graduating. The prizes were presented by Mrs. Hamilton, Mrs. Thompson and Miss Henry. A reception was then held for the class and their friends.

On the evening of June 3rd, the Alumnae Association gave the annual banquet for the graduating class at the Royal York Hotel. The dinner speeches left nothing to be desired. Miss Henry, President, as toastmistress, introduced each speaker with a clever little speech. Miss Meiklejohn's reply to Alma Mater was a fresh inspiration, another ideal to fight for so that the profession may ever carry the brightest light. The guest speaker, Mrs. Cosgrave, gave a brilliant address on "Loyalty," and the toast

to "Absent Members" brought forth very proud and happy memories of those of the School who are working in every country of Christendom. The class history and prophecies, also the musical selections, proved most enjoyable, and all too soon came "Auld Lang Syne" till 1933.

GENERAL AND MARINE HOSPITAL, COLLINGWOOD: The Alumnae officers for the year are: Honorary President, Mrs. Price; President, Miss K. Hanley; First Vice-President, Miss L. Ludlow; Second Vice-President, Miss B. McQueen; Secretary, Miss F. Pearen; Treasurer, Mrs. J. McAllister; Social Committee, Mrs. F. Watts, Misses Robinson and Cooper. Meeting will be held the last Friday of each month at 3 p.m. in the Board Room of the Collingwood General and Marine Hospital.

DISTRICT 6

A meeting of Chapter 3, District 6, Registered Nurses Association of Ontario, was held in Ross Memorial Hospital on June 3rd. The meeting was called to order by the chairman, Miss Dixon, who gave a short talk on the R.N.A.O. Members of the medical profession, by their presence, honoured Dr. G. Stewart Cameron, who, as the speaker of the evening and Chairman of the Joint Study Committee, gave a profound address on the Report of the Survey of Nursing Education in Canada. A hearty vote of thanks was given to Dr. Cameron by Mr. T. H. Stinson, K.C., M.P. Refreshments were served by Miss Reid and her assistants at the close of the meeting.

DISTRICT 8

CIVIC HOSPITAL, OTTAWA: Miss Jean Forbes and Miss Ida McDowell (1931), who were among those receiving certificates for Public Health Nursing from the School for Graduate Nurses, McGill University, have accepted positions for the summer with the Victorian Order of Nurses, Montreal.

The Graduating Class of the Ottawa Civic Hospital School of Nursing was entertained at dinner on Monday, May 30th, in the Chateau Laurier by the Alumnae Association. The decorations were effectively carried out in the school colours of purple and gold, and as a souvenir of the occasion each guest was presented with a gold pencil. Miss E. Pepper, president of the Alumnae, presided, and Miss Jessie Muir, the guest speaker of the evening, gave an interesting talk, taking as her subject, "Here and There Abroad". Miss G. Bennett spoke words of greeting to the guests and members of the Alumnae.

Part of the programme consisted of the following toasts: "The Doctors," by Miss Gertrude Maloney; "Our Guests," by Miss Edna Osborne, and responded to by Miss Dorothy Dent; "The Absent Members," by Miss M. Lamb, responded to by singing of "There's a Long, Long Trail"; "The Staff," by Miss Mary Graham, responded to by Miss Marion May. The class prophecy, read by Miss Maymie Downey, was greatly appreciated by all present.

An enjoyable musical programme was provided.

Prior to graduation the class was entertained at a social evening given by the Alumnae in the Nurses' Residence on Friday, May 20th, and to a theatre and supper party tendered by the Intermediate class of the School on May 27th.

Fifty-six nurses received their diplomas and medals on June 1st, 1932. Following the Graduation Exercises, which took place at three o'clock, a delightful garden party was held on the Hospital grounds.

QUEBEC

GENERAL HOSPITAL, MONTREAL: Graduates of M.G.H. who attended the C.N.A. general meeting in Saint John, and were all present at a dinner at the Admiral Beatty Hotel on the evening before their departure for their respective homes, were as follows: Misses Jennie Webster, Mabel Holt, Frances Upton, Beatrice Hadrill, Christena Watling, Agnes Jamieson, Eleanor Hancock, Madeline Taylor, Delia I. Mignot, Mrs. Eva M. Bertrand and Mrs. Stuart Ramsey, of Montreal; Misses Gertrude Bennett, A. Grace Tanner, Hattie P. Tanner, of Ottawa; Miss Nell Tuck, Newfoundland; Miss Marion Boa, New Glasgow; Elsie Tulloch, Woodstock; Misses Alice M. Brewster, Alice B. Wilson, Mrs. J. N. Barry (nee Clark), Mrs. A. S. Kirkland (nee Roy), Mrs. Walter (nee Babbitt), Mrs. John Gale (nee DeCon), Mrs. L. C. Rudolph (nee Journeay), of Saint John; Miss Mary V. Lovering, Toronto; Miss Margaret Taylor, Sweetsburg, Que.; and Miss S. A. McGrand, Welsford, New Brunswick.

SHERBROOKE: The last meeting for the season 1931-1932, of the Eastern Townships Graduate Nurses Association, took place in the McKinnon Memorial Building and was well attended. An interesting feature was four papers read on the Survey Report, following which the usual business was transacted. The meeting closed after serving refreshments.

Miss Helen Buck, Superintendent, Sherbrooke Hospital, attended the convention of the Canadian Nurses Association in Saint John.

WOMEN'S GENERAL HOSPITAL, WESTMOUNT: The members of the Graduating Class of 1932 were the guests of the Alumnae Association at dinner on the evening of June 13th at the Queen's Hotel, Montreal. The Graduation Exercises were held in the Hospital on the afternoon of June 15th. Dr. Ridley MacKenzie presided. The invocation was pronounced by Rev. Dr. H. L. Fisher. Dr. A. O. Freedman addressed the graduates. A reception was afterwards held in the Nurses Home. The medals and diplomas were presented by Dr. H. L. Reddy, Medical Superintendent.

SASKATCHEWAN

GENERAL HOSPITAL, MOOSE JAW: At the annual meeting of the Alumnae held at the Nurses' Residence, Moose Jaw General Hospital, May 31st, 1932, the following officers were elected: Honorary President, Mrs. M. A. Young; President, Miss O. Finlay; First Vice-President, Miss E. M. Heglin; Second Vice-President, Mrs. N. Buckley; Recording Secretary, Miss P. Grigg; Corresponding Secretary and Treasurer, Miss B. McQuarrie; Visiting Conveners, Mrs. C. Stansfield and Miss E. Carter; Social Conveners, Mrs. J. Droppo and Mrs. W. Hinchey; Private Duty Convener, Mrs. M. Fitzgerald; The Canadian Nurse Representative, Miss A. Cheavins. Miss L. Carter was in charge of the meeting. Miss Cheavins gave a report on the activities of the past year, and the treasurer, Miss Windsor, presented the financial report, showing a substantial balance.

VICTORIAN ORDER OF NURSES

Miss Elizabeth Smellie attended some of the sessions of the Annual Meeting, Canadian Medical Association, while in Toronto in June, on her way west on a short tour of the Western Branches of the Order.

Miss Cryderman, Central Supervisor, Miss Dawson, Maritime Supervisor, Miss Dorothy

Percy, Central Office and Chairman of District 8, R.N.A.O., attended the meeting of the C.N.A. Miss Moag and Miss Marion Nash of Montreal Branch were also present and took part in section programmes.

TORONTO BRANCH: The annual staff picnic was held at Centre Island on June 14th, when thirty-four staff nurses and eight student guests enjoyed the plentiful and delicious "eats" and spent a jolly evening. This picnic is arranged each year before the students from the Department of Public Health Nursing, University of Toronto, complete their field work. Each ferry after five-thirty brings its group of nurses till all are assembled round the table by seven o'clock. After tea this year many groups walked round the shore to Hanlon's Point and took the ferry from there.

Mrs. John Godfrey, Convener of the Advisory Nursing Committee, entertained the staff at a delightful tea at her beautiful summer home at Port Credit on June 22nd.

Miss Edith Campbell, Superintendent of Toronto Branch, and Miss Vera Allen attended the meeting of the C.N.A. in Saint John, and enjoyed the picnic on the river arranged by Miss Ada Burns of the Saint John Branch, and the breakfast at which twenty-four V.O.N.'s were present.

BIRTHS, MARRIAGES AND DEATHS**BIRTHS**

BROWN—Recently, to Mr. and Mrs. W. Brown (Margaret Guy, Owen Sound General and Marine Hospital, 1921), a daughter.

HAMMOND—On June 3, 1932, at Toronto, to Mr. and Mrs. Hammond (Norah Gordon, Toronto General Hospital, 1926), a daughter.

JOHNSON—Recently at Vancouver, to Mr. and Mrs. Robert Johnson (Marjorie Kelly, Vancouver General Hospital, 1931), a daughter.

KING—On June 9, 1932, to Dr. and Mrs. Joseph King (Vera Vance), a son.

MOLLETT—Recently, to Mr. and Mrs. C. Mollett (Doris Hearn, Owen Sound General and Marine Hospital, 1924), a daughter.

MCALLUM—Recently, at Vancouver, to Mr. and Mrs. A. McCallum (Ruth Mitchell, Vancouver General Hospital), a daughter.

SAWYER—In June, 1932, at Peterborough, Ont., to Mr. and Mrs. Thomas Sawyer (Gladys Lewis, Hamilton General Hospital, 1927), a daughter.

SMALE—On June 23, 1932, at Toronto, to Mr. and Mrs. Fred Smale (Margaret Service, Toronto General Hospital, 1927), a son.

STEWART—On June 2, 1932, to Mr. and Mrs. Maynard Stewart (Alma Muriel McKnight), of Britannia Beach, B.C., a daughter.

WHITE—On June 6, 1932, at Chatham Ont., to Dr. and Mrs. C. C. White (Inez Roach), a son.

WILLS—Recently, at Mount Hamilton Hospital, to Mr. and Mrs. Wills (Thelma Ronson, Hamilton General Hospital, 1927), a son.

WILSON—Recently, at Vancouver, to Mr. and Mrs. William Wilson (Norah Rodden, Vancouver General Hospital, 1919), a daughter.

MARRIAGES

ALLEN—**GREENWAY**—On June 16, 1932, at Ottawa, Ont., Marjorie Greenway (Ottawa Civic Hospital, 1928) to John S. Allen, of Osgoode, Ont.

DUGGAN—**KELLEY**—In June, at Guelph, Ont., Anne Kelley (St. Joseph's Hospital, 1929) to Victor Duggan, of Toronto, Ont.

FARNELL—**LA FONTAINE**—On June 4, 1932, at Vancouver, B.C., Evelyn Elizabeth La Fontaine (Vancouver General Hospital, 1931) to William Ralph Farnell, of Vancouver, B.C.

GORE—**MILNER**—Recently, at Vancouver, B.C., Viola Milner (Vancouver General Hospital, 1928) to Mr. Gore.

GRANGER—**HUMPHREYS**—Recently, at Vancouver, B.C., Annie Dorothy Humphreys (Vancouver General Hospital, 1920) to Ernest Granger, of London.

HOELSCHER—WARD—On June 29, 1932, at Kitchener, Ont., Mary Elizabeth Hamilton Ward to John Martin Hoelscher.

MONTGOMERY—GOSNELL — On April 30, 1932, Muriel Gosnell (Chatham General Hospital, 1927) to John Montgomery.

MORGAN—JONES — Recently, at Vancouver, B.C., Ruth Jones (Vancouver General Hospital, 1930) to Cyril Morgan.

McCANNELL—DENNIS — On June 20, 1932, at Guelph, Ont., Edema Dennis (Guelph General Hospital, 1929) to Elmer McCannell, both of Guelph.

PHINNEY—McKIVOR—On May 17, 1932, at Vancouver, B.C., Evanda McKivor (Vancouver General Hospital, 1928) to Laurence Hudson Phinney, of Winnipeg, Man.

REDFERN—MACLAURIN — On July 2, 1932, at Point Fortune, Que., Margaret Evelyn MacLaurin (Toronto General Hospital Public Health Course, 1929) to Harvey Redfern, of Ottawa.

STERLING—BROWN—On June 21, 1932, at Woodstock, Ont., Hannah Brown (Woodstock General Hospital, 1923) to Harry Sterling, Phm.B., Woodstock, Ont.

TAYLOR—DYNES—On June 15th, 1932, at Orangeville, Ont. Sadie Esjelle Dynes (Lord Dufferin Hospital, 1931), to W. H. Taylor of Grand Valley, Ont.

TURNBULL—PHILLIPS — On June 3, 1932, at Jarvie, Alta., Mina Phillips (Lamont General Hospital, 1929) to William Turnbull, of Winfield, Alta.

DEATHS

FINDLAY—Recently, at Vancouver, B.C., Mrs. Harold Findlay (Florence Shindler, Vancouver General Hospital, 1919).

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Those wishing to write must apply for forms, etc., to the Registrar, and all applications must be in the office of the Association before September 1st, 1932. No application can be considered after that date.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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Meeting, first Monday each month.

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

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The Public and the Survey

By The Hon. VINCENT MASSEY, P.C., LL.D.

I deeply appreciate the privilege of addressing the members of the Canadian Nurses Association on the occasion of their Biennial Meeting. I confess as I look through your programme and see the formidable array of expert knowledge representing so many departments of the professions of medicine and nursing, I wonder just why your distinguished body has been exposed to the uninstructed observations of a mere layman. But I assume that it is a tradition on such occasions as these, when practitioners of the healing art assemble, to produce a member of the lay public as a sort of exhibit, to keep their scientific minds down to earth. It is, therefore, as a representative of what might be called the raw material of nursing that I am happy and contented to come before you this evening.

It may seem rather obvious for visiting laymen to pay compliments on such an occasion as this, but I can assure you our tributes to your high vocation do not lack sincerity. Perhaps in moments of disappointment or discouragement you may not be aware of the profound sense of gratitude which the public as a whole feels towards the great corps of nurses to whom it owes so much. I know for my part I feel that anything which may be said by way of praise or compliment to the nurses of Canada can only involve one error, that of understatement. I have been reading here and there enumerations of those virtues which should be the possession of the ideal nurse. On perusing these statements, they seem so complete, so all-embracing, that one might think one was scanning the specifications

for an archangel, but there are few of us who have come in contact with representative members of your profession who do not know how often such lists of qualities are in no sense an extravagance.

I am glad to know that a profession which means so much to our young country has grown in numbers so strikingly in the present generation. One can hardly believe that in less than twenty years the number of nurses and student nurses in Canada has increased more than five times, from fewer than 6,000 in 1911 to more than 30,000 in 1930. This is not simply a reflection of the wider application of medicine or the general growth of medical personnel. As it happens there are relatively fewer doctors of medicine in Canada today than there were ten years ago. In 1921, we learn there was one physician to 947 people in Canada. In 1930, the ratio had dropped to one to over 1,000 of the population. In the corresponding period the relative number of nurses has, however, risen strikingly. Ten years ago we are told there was one nurse to 411 persons. Now apparently the figure is one to about 340. This significant growth in the number of nurses in Canada covers the period of the war. We had some 5,000 nurses in 1911. By 1921 the numbers had risen to over 21,000. Wars bring few benefits to society, but your profession provides an exception to this rule. Just as it was the ordeal of the Crimean campaign which through Florence Nightingale's genius first gave trained nursing to the world; it was the Great War which elevated your profession to the high place which it occupies in the community today.

The increase in the number of nurses in Canada in the last decade suggests several important conclusions. It most certainly makes clear that there is no dearth of young women in our country who are prepared to enter an arduous service. Again, the growth in your numbers in response to public demand reveals a national recognition of the importance of your functions. It indicates, too, and this is most significant, a pressing obligation on the part of the public of today to consider the status and to recognise the needs of this great body which has grown up in its midst. There is an urgent necessity for a searching examination into the training, the educational standards, and the economic position of such an important profession and its general relation to the society which it serves. Such an examination one is happy to think has taken place in the recently published "Survey of Nursing Education in Canada," by Professor G. M. Weir, of the University of British Columbia. I should like to congratulate not only Professor Weir on a most admirably conceived and executed survey, but also the Canadian Nurses Association and the Canadian Medical Association, under whose joint auspices it has been conducted, on the imagination with which this most important inquiry was undertaken.

The thoroughness of the examination is most impressive. Nothing seems left out. For one fleeting moment I thought the inquiry too searching. On turning its pages I saw the heading, "Appraisal of the Patient," and then a few pages on something about intelligence tests. "Good heavens," I said to myself, "has the patient been appraised too?" And my mind ran back to occasions when I should have shrunk from such an assessment, and I could think of such adjectives as irritable, unruly, impatient, which could have been applied. And these intelligence tests! Are patients to be submitted to intelligence tests as well as to other forms of tests? A terrifying thought!

But I was comforted to discover that the appraisal of the patient meant appraisal by the patient. I am sure that there are few nurses who would not emerge from such an examination with satisfactory honours.

There is, of course, no greater indication of vitality on the part of any institution than a spirit of self-criticism. Complacency and self-satisfaction can only indicate stagnation and inertia. On reading the Report one is conscious that the actuating motive behind its inception has not been only to seek a remedy for the economic difficulties in which the nursing profession finds itself today, great as these are, but also by taking the long view, to see in what manner the profession may equip itself even better to serve the community to whose welfare it is dedicated. I wish that more organisations would from time to time address themselves as you have to such an honest self-criticism and broad-minded inquiry as is revealed in Professor Weir's Report.

I am glad to see Canadian nursing approached as a national Canadian problem. It is only by so viewing it that we can deal with it appropriately. Nursing has a peculiar relation to Canadian history and tradition. It represents a significant thread in a national fabric. I entirely agree with Professor Weir in his suggestion that the time has arrived when the history of nursing in Canada might well be written for the enlightenment and inspiration of the Canadian nurse of the future. I am not speaking simply in words of empty compliment when I say that the qualities represented by the profession are such as to inspire a special pride in the minds of Canadian citizens. We have already something not unimportant to teach the world on this great subject. During the years I lived as your representative in Washington I was very conscious of the position which the Canadian nurse occupied in the American community. There are thousands of families in the United States whose knowledge of Canada is

limited to those representatives of your profession who have helped their households through some trying crisis. Nursing, as you probably know, represents one of three or four occupations through which Canadians have acquired an important position in the life of the United States, and although I was sorry to see such people lost to Canada, I was proud of the quality of this "export," if I may use the term, for which your profession has been responsible. You, too, should be happy to realise the standing which your representatives (there must be many hundreds of these, if not thousands), have acquired over the years in the neighbouring republic. When I asked myself, as I often did, just what are the qualities through which Canadian civilisation makes its contribution to the world, I found it always hard to answer in the abstract. But the presence beyond our boundaries of so many nurses whose services are so earnestly sought, suggests the fact that some of the qualities which the outside world recognises as being Canadian and deeply prizes are the qualities represented by Canadian nurses, born in Canada, educated in Canada, and trained in Canada. All honour to them.

Nursing, let me say again, is a peculiarly Canadian subject, so I am glad to see that we are examining this great Canadian profession through Canadian spectacles. Science, it is true, will tolerate no national boundaries, and should have no such limitations imposed upon it, but in the application of scientific knowledge the practice of one nation may differ from that of another. I think it entirely right and fitting that in all departments of the great field of medicine, as indeed in all else, we should ask ourselves what is the appropriate way to do a certain thing in terms of Canadian life and Canadian traditions. There is more often than we realise a definitely Canadian way of doing things. This will frequently differ from the practice of other people who in many ways are much like

ourselves. It may be an impertinence for a layman to say so, but I think there is a very great danger that we should, even in the field of medicine, accept unthinkingly practices and principles which may be appropriate in another country but not be so applicable to our own. For one thing, we have a relatively small population. It is unnecessary for us to imitate a larger nation in terms of mere magnitude and complexity. We are often able to keep the virtue of simplicity, not forgetting that simplicity is virtue. We have through the years developed in medical science our own traditions in many respects, and have struck our own qualitative standards. Let us be true to them.

If I may carry this indiscretion a step further, I should like to suggest that in the intense specialisation of American medicine there is a very definite evil for us to avoid. It is true that with the growth of scientific knowledge its content must be more and more departmentalised, but such subdivision cannot be allowed to escape the over-riding synthesis of trained and educated minds. The system to which the patient may now be frequently exposed in the interest of the diagnosis and cure of his ailment no doubt reveals an efficiency no less striking than that which has made Mr. Ford's factories so famous. But surely mere mechanism must be a complement to, and not a substitute for, a wise intelligence which views the human body as a whole and not merely as an assembly of spare parts. One of the greatest dangers with which society is confronted today, in my opinion, is the danger that comes when a specialist directs instead of remaining an advisor. Society would collapse without the expert, but when he is in control, whether the field be a Disarmament Conference or a College of Medicine, the whole will almost inevitably be sacrificed for the part. A recent writer has pointed out that most men long trained in a special experience have a vision limited by the character of that experience. The great profession of healing as

represented in Canada, however, is happy in possessing many men who, like Sir William Osler, have the vision to see their own branch of knowledge in relation to life as a whole. Let us remain true to this tradition. I congratulate the director of your Survey on approaching his great subject in precisely this spirit. Whether he is discussing the education of nurses, or the employment of nurses, or the relation of the nurse to the doctor, he takes the broad view. Your profession will be the greater for the perpetuation and embodiment in its future plans of such an attitude of mind.

In many ways, as a matter of fact, the nurse is a conspicuous example of the importance of balance and proportion in personal qualities, in education and in professional outlook. For one thing, no calling so demands a delicate adjustment between head and heart. Enthusiasm, a spirit of service, capacity for sacrifice,—these are obviously essential, but one would not contentedly hand over a major surgical dressing to a nursing attendant in whom emotional fervour took the place of professional knowledge and skill. Laboratory training is essential, but a nurse is only half a nurse whose interest in test tubes and chemical formulae is so great as to exclude the human element. I was interested in seeing that your Survey invokes the names of two great figures, one from our early French history and the other from our English tradition, who suggest in their own careers these two great blended elements in the nursing profession. Jeanne Mance, the heroic French woman, who almost three centuries ago established her hospital at Montreal, was the first Canadian nurse—the first North American nurse. It might be well if her memory could be commemorated by the profession of today as its virtual founder in Canada and one who represented in a high degree the spirit of passionate devotion and self-sacrificing service which runs like a bright thread through the history of your vocation down to the present. The other figure

is, of course, that of Florence Nightingale. Despite the sentimental interpretation of her character—the legend of the “Lady of the Lamp”—she represents the intellectual quality no less essential to the balanced nurse. Lytton Strachey has painted her correctly, the woman of education, possessed of a veritable demon for reform, and the spread of medical knowledge and its application, before whose righteous fury medical officers wilted and ministers of war succumbed. But both these great women possessed the ideal qualities of the nurse in true proportion. Jeanne Mance supplemented her missionary zeal with an organising capacity which left the Hotel Dieu at Montreal to stand for generations as the doyen of Canadian hospitals. On the other hand, Florence Nightingale, for all her commissions and blue books, was primarily a great nurse, revealing not only genuine statesmanship and genius for organisation, but in her personal service the human compassion which was the actuating motive of her extraordinary life. They both had, too, a touch of that divine madness without which great accomplishments can seldom be achieved—an obsession with the objective to be attained which reduces all things in terms of one dominating theme. I like the story which Strachey tells of Florence Nightingale. During a period when she was engaged in the reform of the medical services of India—incidentally from her sick-bed—she had a visit from a great religious leader, the Aga Khan. “She expatiated on the marvellous advances she had lived to see in the management of hospitals, in drainage, in ventilation, in sanitary work of every kind. There was a pause; and then, ‘Do you think you are improving?’ asked the Aga Khan. She was a little taken aback, and said, ‘What do you mean by ‘improving’? He replied, ‘Believing more in God.’ She saw that he had a view of God which was different from hers. ‘A most interesting man,’ she noted after the interview; ‘but you could never teach him sanitation.’”

I think it significant that your Survey, although it covers all sides of the problem of modern nursing in Canada, should be given the title, "Survey of Nursing Education." The report deals exhaustively with the functions of the profession, the administration of nursing services, and the financial status of the nurse, but education and training are regarded as so fundamentally important as to provide the title of the whole work. This I believe is entirely right. These questions are basic. Of first importance are the training of nurses and the education which should lie back of that. But these are, of course, two vastly different things. The *training* for any profession should equip the candidate with the tools to work with, but whatever *education* he or she is able to acquire has as its purpose the training of the mind for the more intelligent use of these tools. I should like unreservedly to throw myself on the side of those who believe that the technical training for any profession should be accompanied by, or preceded with, as adequate and liberal an education as circumstances make possible. Your Survey points out the slender requirements which are now demanded of the candidates for a course in nursing in some parts of our country. In some cases the nurse-to-be, we learn, enters her career with whatever learning can be acquired in the elementary school and no more. The average standard of education required in Canada is that of two years in the High School—sometimes two years of only six months each—and one may be sure that the career of a nurse in training allows for no leisure to amplify a liberal education which has been prematurely interrupted. This is no place in which to discuss details and it would be an impertinence for me to attempt to do so, but I hope it is not inappropriate here to express the belief that it is in the interests both of your great profession and the public which you serve, that the educational standards demanded of the candidates who request admission to your ranks should be steadily

and generously raised. Nursing as a great calling deserves better than that it should be left as the Cinderella of the professions in the matter of educational standards.

The principles on this subject expressed in your Survey can, of course, be applied to all professions. The scientist, however brilliant he may be, is severely handicapped if he cannot express the results of his experiments in clear and lucid English. One might go further and say that the lawyer is a less effective lawyer whose training has been so narrow as to be limited to the technique of the law. An engineer is a better engineer if his imagination has been stimulated by something beyond his routine training. I have no doubt in my mind that a nurse is not only a happier woman but a better nurse as well if she is in the possession of what a liberal education can give her. The objections raised by the reactionary to such an opinion as this, it seems to me, not only reflect a narrow view of the nursing functions, but also reveal a misconception of education itself. What should be the contribution of the years spent in study in a High School? I refer, of course, to the time after the mere tool subjects, "The three R's," have been acquired. To put it plainly, what good to the trained nurse will be the history, languages, geography, literature, mathematics, she may study before commencing her training? She will, of course, learn little of which she can make a direct application to her future work. She will not be able to apply her knowledge of the French Revolution, or her recollection of German verbs, or even a painful memory of Algebra, but through such mediums as these, however few facts she may remember, she will have been helped if properly taught to acquire a trained intelligence, a balanced judgment, a quickened sympathy, and a cultivated mind. All these qualities, I think I can suggest without fear of contradiction, are not without significance in the sick-room, or in the hours

off duty. I mention the latter because we must not forget the use of leisure in our consideration of a nurse's education. Education must equip us for recreation as well as for work. The best test of a liberal education, indeed, is to ask how far does it equip us to make an appropriate use of what leisure we have. I apologise for these observations on education. They may, I am afraid, appear very elementary to this audience tonight. You, I am sure, would not disagree with me in what I have said, but here and there we know there still exist honest-minded observers whose views on this subject possess what I hope it will not be offensive to call a primitive simplicity and to whom one will be pardoned for speaking in equally simple terms.

So much for this important question of education. There is another even more urgent problem which is pressing for solution just now. It is presented by two striking statements in the Survey, which read in conjunction are very far-reaching in their implications. Forty per cent. of the nurses engaged in private service, we are told, are at present almost continuously unemployed. The average private duty nurse, for example, is apparently in work for fewer than thirty weeks in a given year. Again, there are at present in Canada over 7,600 inactive registered nurses. So much for that side of the problem. On the other hand, fewer than thirty-eight per cent., just over one-third, of those persons in Canada who require nursing services are able to obtain them. In other words, nearly two-thirds of the people in this country ill enough to need the services of a trained nurse cannot afford to employ one and are forced to fall back on the care of unskilled attendants. I fancy that most of us in the non-medical world were unaware of this serious gap between the supply of nurses and those who need their services.

This dis-equilibrium has no doubt been aggravated by the present mal-adjustment of our economic life, but after all hard times frequently bring

out in higher relief the evils which normally exist unseen behind the facade of artificial prosperity. At present, the nursing profession is suffering in an economic sense from deficiency of employment, just as the public is suffering in a medical sense for the want of nursing services. Both problems are sufficiently grave, and the former, I think, little understood. Most people have entertained an entirely false idea of the earnings of a nurse engaged in private service. If the patient multiplies his nurse's weekly cheque by fifty-two and thinks he has arrived at her yearly income he is vastly mistaken. The average private duty nurse, so we are told, in most parts of Canada, earns annually less than that of the elementary school teacher in the same province. And the latter, we must remember, enjoys steady employment, an annual vacation, and for the most part, I believe, participation in a pension scheme. On the other hand, under present conditions it is quite clear the public suffers too. We have made some effort to provide for the indigent, it is true, but to the wage-earning family and the family of moderate means, the cost of a serious illness presents a grave and, in many cases, an insuperable problem. What is to be done? The Director of your Survey has seized the nettle boldly and has advocated a socialised nursing service, based, if possible, on a system of state health insurance. I shall not attempt to discuss details. In fact, there is enough material for many discussions over the broader principles involved before details can even be considered, but if our present system of nursing is breaking down, as I think it is fair to say it is, something must be done to reorganise it on an equitable basis. And I am very glad that this proposal has been fairly and squarely placed before the public in this frank and intelligent manner.

The proposal in the Survey involves a very definite innovation in Canadian institutions. In Canada it is true the principle of state medicine is already established within certain

limits. Public health is not only the responsibility of Provincial Governments, but in some of its aspects it is represented by the activities of a Dominion Government Department. The community as a whole supports an increasingly large number of public health nurses. Over half of the patients in our hospitals which possess 300 beds or more, we learn, belong to the indigent class, and the state, through various governments, municipal and otherwise, assumes the responsibility for their care. But to advance from the present situation to the assumption of some measure of general responsibility for the medical care and nursing of the individual members of the community is a striking development in policy. State medicine, health insurance, socialised nursing, these are terms which I am sure will evoke murmurs of "paternalism" and socialism on the part of those who have honest doubts as to the wisdom of such innovations. We shall be told that we must do nothing to weaken the moral fibre of our people, that we must preserve a healthy individualism, that we must not undermine the robust pioneer spirit of this country, that we should not hamper the enterprise of a young nation by the straight-jacket of socialistic laws, that we must not suppress the element of healthy competition in the nursing profession through the dead-weight of a bureaucratic control. The risk of the suggested innovation may be real or fanciful, but let us remind ourselves again of the problem with which we have to cope. Our present system of nursing is fraught with both waste and injustice. Let me say again, only three out of eight people in Canada so ill as to require the care of a trained nurse can afford to engage one. On the other hand, two-fifths of the trained nurses in Canada are unemployed, and nine-tenths of them are within reach, geographically, of less than half our population. Can we escape a fundamental reorganisation of nursing services so that this serious gulf between supply and demand can be permanently bridged?

It can be done, I believe, in only one way, by the assumption of this responsibility by our community as a whole, and by the organisation of nursing on the basis of a public service, giving the public the benefit of nursing at low cost and the nurse the boon of security in employment. (Needless to say, of course, such action can only be taken by the provinces which under our constitution have jurisdiction over such matters.)

I was struck by the analogy suggested between this present problem and a controversy which now seems to belong to the remote past. The arguments urged against the assumption by the state of a responsibility for the health of its citizens are closely paralleled by the protests a century or so ago against the admission of a public obligation to educate the individual. I believe we have reached the point where we can admit that if the citizen has a right to education, as we believe he has, he has an equal right to health. It is, therefore, I would submit, the collective duty of society to see that whatever medical science can do in the aid of human beings shall be done.

One of the very real dangers inherent in any plan for state administration in the field of nursing is, of course, that of a bureaucratic control which would deaden initiative and enterprise. But we can surely save nursing from the present waste and confusion from which it suffers and place it on a proper basis without involving any such consequences. There is no reason to suppose that the profession cannot be organised as a public service without the loss of any of those essential virtues such as initiative and enterprise which are supposed to be limited to a purely competitive system. The personnel of the Royal Navy does not lack either initiative or energy although Government vessels have long since replaced the old privateers. With the development of a naval service, indeed, came an *esprit de corps* and a new efficiency based upon it. So would it be with nursing. I believe, too, that another contributing factor to the increased

efficiency of this profession would be the relief of its members from the burden of financial insecurity which so oppresses them today.

The critic will, however, say, "This is all very well, but who is to pay for this government system of nursing?" It may be that a socialised nursing service can only be properly financed when based on a general contributory system of health insurance on a compulsory basis. This, in my personal opinion, must come. But the revenue from even that source would doubtless have to be supplemented. We must not shrink from taxation for such a purpose. The burden of taxes now, it is true, is great and growing, and caution as to fresh expenditures is, of course, wise advice. But let us remember the object we have now in view. Public health might well come before some other things which have made a drain on our public treasuries. Economies, too, might help to finance a state nursing service—not panic economies, but the normal economies which were "bad form" in the "frenzied twenties."

Less extravagance in hospital construction itself might be of assistance. At all events, a way must be found. If it is said such luxuries must wait, and that we should cut our coat according to our cloth, I think we must reject the old maxim in its relation to this problem. We must find the cloth to make the necessary coat. If we are to believe what we are told of the situation at present, it is clear that the reorganisation of our nursing services to meet an urgent need is a necessity second in importance only to the relief for those for whom there is no work. We have therefore not only a problem serious enough in normal times, but one which must be given consideration without delay even in the present emergency.

I have no doubt as to our ultimate decision in this important matter if we deal with the matter on its merits. The discussions about paternalism, individualism and socialism relating

to this problem are for the most part unreal. The good British practice when there is a job to be done is to do it, and let the "isms" take care of themselves. The tags can be applied by the theorists later on. The proposed innovation is not so radical a departure as it might seem. Canada has considerable experience in the actual operation of nursing as a public service. The Victorian Order of Nurses has shown us how an *esprit de corps* and high efficiency can be maintained and promoted in a permanent body of nurses.

May I say, in passing, how glad I am that your Survey recommends the wide extension of this splendid corps? It would be a thousand pities if in our endeavours to deal adequately with the field which the Victorian Order has made peculiarly its own we allowed ourselves to duplicate or replace this tried and experienced service. The Order is one of those essentially Canadian institutions which make us proud to be Canadians. I hope we may see its operations widely extended.

Chairman, ladies and gentlemen, I have said all that I should say. Between the conclusions of your Survey and the opinion in your ranks I take it there is little disagreement. Between your views on this great subject and the general opinion of an intelligent public, I feel sure there will be no great disparity of view. Let us hope this will be so. The fundamental problem is, after all, simple, despite the complications involved in its solution. We know what nursing means. We would see its blessing extended so that none may be denied. In a recent life of Sir William Osler there is the following quotation (may I apply it to the nurse?): "And he took the clay in his hand and said, 'This is without flaw. I will mould a vessel that can stand heat and frost and hold cool water for parched lips.'" Our unquestionable aim should be that none in our community should be denied all the aid and comfort which this vessel can provide.

Whither? Presidential Address

By FLORENCE H. M. EMORY, President

Some of you have, no doubt, read an address delivered by Sir James Barrie at his installation as Chancellor of Edinburgh University, entitled "The Entrancing Life." Among other characteristic things, he points out to the student body that it is easier to cry "Onward" than to say "Whither." Until now the nursing group has been in that position precisely. Today it can scarcely be said with truth that we are without a compass for direction and a chart for instruction in reaching the promised land. Future days will reveal the degree to which an adventurous spirit will go forward and possess the land. For adventure is still the dynamic of professional life; its energising or motive force. And never has the Canadian profession been privileged to respond to a challenge so alluring, so absorbing, as that of this hour. Supremely it is an hour for stout hearts and clear heads and, given a will to accept the challenge, "fair haven" will be reached if unity, perspective and conviction be reflected in the venture.

Unity in Adventure

The two years just past have revealed unity of purpose. From coast to coast three immediate objectives have been adopted: to increase national membership, to appoint an editor for *The Canadian Nurse*, and to make effective the Survey of Nursing Education in Canada. There was an average gain in the membership of the nine provincial associations of 29% during the period 1926-1930. For the year 1931 a gain of approximately 600 or 7% over 1930 is recorded. Actual membership in the Canadian Nurses Association in 1931 was 8,624 and potential membership 15,797. That is, if every active registered nurse belonged to a

provincial organisation, the national membership would be 15,797. Further effort is indicated. In the fall of 1930 a committee was appointed to study matters relating to the change of the National Office and the securing of an Editor for *The Canadian Nurse*. The ground was canvassed thoroughly, the Executive accepting, finally, the recommendations of the committee. These have been considered by provincial associations with a view to voting upon them at this meeting. The Association will do well to sanction a change of location in the National Office and to appoint an Editor for our official organ. That would release the Executive Secretary of the Canadian Nurses Association for closer contact with, and further development of, provincial associations.

Further, there has been unity of action. A spirit of adventure resulted in a changed basis of membership two years ago. At that time the Canadian Nurses Association became a federation of provincial associations, with membership in the National Association and in the International Council of Nurses through provincial organisations only. Increased contact between provincial units and the Canadian Nurses Association has resulted in a strengthening of both. Witness, for instance, plans made for the publication of the Survey Report. It was possible to work closely with provincial presidents and secretaries in an attempt to create a right attitude toward the findings, in safeguarding publicity and in the sale of Reports. The formation of provincial Joint Study Committees will go far in determining lines along which provincial action should be taken. Resultant strength from a change in the basis of membership is a marked feature of the period 1930-1932.

Unity of purpose and action are incongruous without unity of spirit. In the long last that is of vital import. There has been apparent from the east to the west that subtle, intangible thing: that thing which somehow lends a feeling of solidarity to professional endeavour. Evidence has not been wanting of a united participation of individuals and groups in moral and actual support of professional projects. Professor Urwick in his book entitled "A Philosophy of Social Progress" accentuates the value of things of the spirit. "All actions," says he, "derive their value from the part they play in the working out of the spiritual process, not from their immediate or apparent effects upon social progress. In the spiritual scale of values it is not the success of the treatment applied by the Good Samaritan which counts for much any more than it is the actual purchasing power of the two mites given by the poor widow, but simply the fact that the one did his best in a spirit of neighbourliness and the other gave her all in the spirit of sacrifice."

Perspective in Adventure

One of the pressing needs of the individual and of society is perspective. It was true in the pre-Christian era. It is true today. Of Plato it is said that he was a balanced soul, that he could see two sides of a thing. The Survey has provided perspective: it has taught us afresh that truth is many sided. At all events, it has been scientific in approach and method. Some of its findings cut deep. They strike to the core of nursing difficulties. In its pages the student nurse is portrayed. Her intelligence, her health care are examined. The nursing school is brought to the footlights, with the conclusion that financial support from the State is necessary if schools of nursing are to take their place with schools giving preparation to a sister profession. A fitting analogy is drawn between the normal school and the nursing school and oft

repeated. Take courage! A quotation from "Public Education in Upper Canada," by Herbert Coleman, is apropos. Writing of the normal school in Toronto in 1847, he says "that Ryerson's efforts to establish a normal school were not sympathetically received in all quarters is illustrated by the following extract from a memorial sent to the Provincial Legislature in 1847 by the Gore District Council. After a reference to the school in question as entirely unsuited to a country like Canada, the statement is made, 'nor do your memorialists hope to provide qualified teachers by any other means in the present circumstances of the country than securing as heretofore the services of those whose physical disabilities from age render this mode of obtaining a livelihood the only one suited to their decaying energies, or by employing such of the newly arrived emigrants as are qualified for common school teachers year by year as they come amongst us and who will adopt this as a means of temporary support until their character and ability are turned to better account for themselves.' The memorandum was sent to the various district councils of the province with the hope of securing their concurrence."

Nursing conditions revealed by the Survey could be scarcely less promising than those of the teaching profession not one hundred years ago. Perhaps the most intriguing and stimulating chapters of the Report are those devoted to a discussion of the control of the graduate nurse. The socialisation of nursing services, with the formation of District Registries, of Provincial and Federal Nursing Councils, appear to offer a penetrating and intelligent, if somewhat remote, solution of baffling problems.

The Survey will provide content for convention programmes for years to come. It is a challenge to grapple with things as they are, and we are pledged to assist in making it effec-

tive. The value of the Report rests not only in providing the profession with an immense body of subjective and objective data; it has brought together in national and provincial Joint Study Committees those who have power to improve the situation. Then, too, unity, the warp and woof of professional life, has been intensified within the nursing family in the face of common danger. A word of caution! This Report is not the final publication on nursing affairs in Canada. The profession should anticipate a second Report indicating accomplishment, revealing new truth. Truth is never so complete that it may not be augmented. The desire of humanity is to be settled. The hope of the future lies with those who refuse that dictum; with those who welcome and are susceptible to an increasing body of new thought.

Conviction in Adventure

The Survey has provided perspective in a revelation of existing conditions. I submit that conviction is necessary to their solution. Just here the realist is needed. The one who sits down before facts and lets facts speak to him. He recognises the problem interpreted by factual data. He has an unprejudiced attitude toward truth. With humility, discriminating judgment and detachment of outlook he considers a projected solution. In other words, he gives the matter dispassionate consideration. I affirm the realist is needed, but not the realist alone. The idealist is needed too. To realism must be added idealism. With faith in her profession and with an imaginative adventure in the solution of its problems, the idealist is not timorous of future safety. She is prepared to dare. Nothing is more potent than a convinced idealism. The biographer of a recently published life of Florence Nightingale speaks of her as a practical idealist. Just so. She

is the one who can face facts with faith, imagination and conviction; with a sense of victory not defeat; the one who sees in a complex and veiled situation opportunity for endeavour far greater, far more significant than that revealed to the one who is a realist alone.

In adventure, then, we have found a professional dynamic: through adventure we foresee attainment. Whither? On to the twenty-fifth anniversary of the founding of the Canadian Nurses Association in 1934. That will be a time of reckoning, of appraisal. The solution of some problems will require one, two or maybe three decades, others should reflect progress in that two-year period. Of necessity we look to the national and provincial Joint Study Committees for leadership and guidance. For adventure we must: with a spirit of unity, with truth in perspective and with strength of conviction.

A Greek legend depicting the adventures of Hercules tells that one day he met two beautiful women, each of whom offered to guide him on his journey. The first told him that if he followed her he would gain love, riches and ease; the second promised him honour bought at the price of hardship, poverty, endless toil. He pondered the two offers, so dissimilar. Courageously he gave his choice to the second, who henceforth led him along a rough and thorny path, delivering the oppressed, defending the weak, redressing all wrongs. At length he was led into labours such as no man had ever yet performed. Shall we emulate the adventures of Hercules? Shall our choice be the path of difficulty, of honour: the path that will lead to professional attainment greater than has yet been experienced? That is to say: Are we willing to pay the price of professional emancipation? Whither?

Canadian Nurses Association—Sixteenth General Meeting

The Sixteenth General Meeting of the Canadian Nurses Association was held in Saint John, New Brunswick, from June 21st to 25th inclusive, 1932. The Admiral Beatty Hotel proved most suitable headquarters for the convention.

Open Meetings

The sessions held on Tuesday and Friday evenings were open to the public. At each of these meetings there was an overcrowded attendance in St. David's Church Hall.

Tuesday evening, Miss MacMaster, President of the New Brunswick Association of Registered Nurses, presided. Addresses of welcome were made by: The Premier of New Brunswick; the Mayor of Saint John; the President of the New Brunswick Medical Association, and the President of the New Brunswick Association of Registered Nurses. Miss F. H. M. Emory, President, Canadian Nurses Association, expressed the thanks of the delegates and members for the welcome extended. The speaker of the evening was the Hon. Vincent Massey, P.C., LL.D., who discussed the Survey Report from the standpoint of the public.

The vote of thanks to Mr. Massey was made by Miss Jean E. Browne, of Toronto; seconded by Miss Grace Fairley, of Vancouver.

On Friday evening, the President, Miss F. H. M. Emory, presided. The first speaker, Dr. Stewart Cameron, Chairman of the National Joint Study Committee, Canadian Medical Association and Canadian Nurses Association, interpreted the attitude of the medical profession toward the nursing profession and the Survey Report. Professor F. Clarke, Department of Education, McGill University, presented aspects of the Report in his subject, "Life, Profession and School."

Miss K. W. Ellis, First Vice-President, moved the vote of thanks to Dr. Cameron and Professor Clarke, which was seconded by Miss Margaret Murdoch.

General Business Sessions

Business sessions were held on Tuesday morning and afternoon and on Thursday and Saturday mornings. Upon the first session being called to order by the President, Miss F. H. M. Emory, an invocation was offered by Rev. C. G. Lawrence, Rector of Trinity Church, Saint John.

The attendance at these sessions was most gratifying. The total registration was 441, while the attendance at each business session was over 300.

An outstanding feature of the recent meeting was the presence of the majority of the officers and councilors of the Canadian Nurses Association, the officers of the Sections, the conveners of committees and those scheduled on the programme.

At the first session it was unanimously agreed that the Press representatives should be admitted without restriction. The reports released by the Press were comprehensive and accurate. This was greatly appreciated by the Association.

Reports submitted at these sessions, together with all resolutions adopted, are published in this issue. A perusal of the content of the reports indicates the interests, activities and progressive development of the National Organisation. With reorganisation in membership in the past two-year period it has become more evident that the Canadian Nurses Association is the unifying implement among nurses in Canada and also the means by which international relationships are maintained.

General Sessions—Survey Report

At three general sessions selected recommendations of the Survey Report were considered.

1. "The Approved Training School": This subject was introduced by Miss E. Kathleen Russell, Department of Public Health Nursing, University of Toronto, and Nurse Member of the Joint Study Committee. Several angles of the subject were presented, namely: The Superintendent of Nurses and the Instructors, Nursing and Medical, by Miss M. K. Holt, Superintendent, School for Nurses, Montreal General Hospital; The Entrance Requirements, by Sister Ignatius, Superintendent, School for Nurses, Antigonish; The Head Nurse; Hospital Facilities for Teaching; The Curriculum, by Miss G. L. Rowan, Superintendent, Grace Hospital, Toronto; and Concerning Registration in Relation to the Training School, by Miss E. MacP. Dickson, Superintendent, Toronto Free Hospital, Weston.

2. An Analysis of the Cost of Nursing Education: Introduced by Miss Jean I. Gunn, Superintendent, School for Nurses, Toronto General Hospital, Toronto, and Nurse Member, Joint Study Committee. The subjects and speakers at this session were: The Cost of the Student Nurse to the Hospital, by Miss E. M. McKee, Superintendent, General Hospital, Brantford; The Comparative Cost of the Student and the Graduate Nurse, by Miss G. M. Fairley, Superintendent, School for Nurses, Vancouver General Hospital, Vancouver; The Budget System, by Miss M. F. Hersey, Superintendent, School for Nurses, Royal Victoria Hospital, Montreal; and Financial Aid from Government for Nursing Education, by Miss E. Smith, Normal School, Moose Jaw.

3. Miss Jean E. Browne, Director of Junior Red Cross for Canada and Nurse Member of the Joint Study Committee, introduced the subject, "The Distribution of Nursing Services," for consideration at the third session given over to the Survey Report. Those contributing to the programme on this subject were: Miss K. W. Ellis, Superintendent, School

for Nurses, Winnipeg General Hospital, Winnipeg, who presented "Supply and Demand" under three headings, namely: (a) The unemployment of nurses, (b) The reduction of the supply of nurses, (c) Increase in demand for nurses; Miss Eleanor McPhedran, Superintendent of Nursing, Central Alberta Sanatorium, Calgary, discussed Socialised Nursing; and Miss A. J. MacMaster, Superintendent, School for Nurses, Moncton, Dominion Bureau of Nursing, Provincial Councils and Provincial Boards of Control, District Registries.

At each of these three sessions ample time was allowed for general discussion, then the Nurse Member of the Joint Study Committee gave a general summary resultant to the papers read and discussion, and presented related resolutions.

The resolutions adopted at these sessions are published on page 489.

Sections

The three Sections: Private Duty, Public Health and Nursing Education, met concurrently on Thursday afternoon and Friday morning.

At the first session of the Private Duty Nursing Section, the general topic, "Meeting the Public Need for Service," was presented in the following papers: (1) "The Intelligence and Education of the Nurse-in-Training," by Miss Sara Matheson, Montreal, Que.; (2) "The Professional Growth of the Graduate Nurse," by Miss A. McQuhae, Toronto, Ont.; (3) "Hourly and Group Nursing," by Miss E. Frank, Victoria, B.C.; (4) "A Physician's Viewpoint," by Dr. S. R. D. Hewitt, Superintendent, Saint John General Hospital, Saint John, N.B. Discussion was led by Miss A. Jamieson, Montreal. The business session of this Section took place on Friday morning.

The Public Health Nursing Section first disposed of its business responsibilities on Thursday afternoon, then Miss E. H. Dyke, of Toronto, introduced the subject, "Implications of

the Survey to Public Health Nursing."

General discussion was led by Miss Edna L. Moore, of Toronto, and Miss D. Percy, of Ottawa.

The next morning the Public Health Section programme included papers on: (1) "The Education of the Public Health Nurse," by Miss Margaret Kerr, Assistant Director, Department of Nursing, University of British Columbia, Vancouver, B.C.; (2) "Supervision of Public Health Nursing," by Miss Marion Nash, Educational Director, Victorian Order of Nurses, Montreal, Que.; (3) "Supply and Demand," by Miss Esther Beith, Director, Child Welfare Association, Montreal, Que. A general discussion followed.

The Nursing Education Section held a business meeting on Thursday afternoon, followed by a round table on "The Curriculum in Canadian Schools of Nursing and Readjustment in the Educational Programme," which was introduced by Miss G. M. Fairley, Convener of the Committee on Curriculum. Professor F. Clarke spoke briefly at this meeting.

Again on Friday morning, this Section met in round table discussion; the subject was "A Discussion of the Survey Report from the Educational Angle, Dealing with Recommendations Affecting Training Schools," by Miss Marion Lindeburgh, of Montreal.

At the final general session the Chairmen of the Sections submitted reports of the Sections' activities for the two-year period and findings of their respective sessions:

Private Duty Section

During the Section sessions the attendance was large and interest manifested. The papers presenting the different viewpoints of meeting the public need in service were of excellent calibre.

The summary of the provincial reports, as compiled by Miss Jean Church, states that: "On hearing the reports from the Private Duty Section in each province one is struck

by the canopy of gloom which hangs over our branch of nursing at the present time. Troubles seem much the same in each province, namely, a surplus of nurses, very little work and the inability of the patients who require skilled nursing care to pay for it."

As regards local registries, satisfaction is reported from Quebec, Ontario and Saskatchewan, where registries are conducted by the nurses themselves. Were it possible to adopt Dr. Weir's recommendation with regard to registries, many of the difficulties would automatically be removed. If there were a Provincial Registry Office which would advise and supervise central registries, then private registries, including those now conducted by hospitals, would be wiped out of existence.

The increased membership in the central registries would provide necessary funds to maintain fully trained and experienced registrars, who would carry out their duties with no particular favour cast in any direction except perhaps on behalf of the patient, who, after all, is the person most concerned when the nurse is being called.

The provincial reports were unanimous in their opinion that all who care for the sick for hire should be licensed.

Group and hourly nursing: It was pointed out that as far as large institutions were concerned, it seems possible there would be little opportunity for this if graduates were placed on general duty, as has been suggested so often before. There are many difficulties in the way of the practice of hourly nursing by individuals, but it was pointed out by Miss Church that Canada has one of the most efficient hourly nursing services in the world already organised and giving the greatest measure of satisfaction from coast to coast, in the Victorian Order of Nurses. It does not seem as though hourly nursing can be successfully practised by individual nurses without some organi-

sation to help them; furthermore, the trend of present thought indicates the need for more supervision of all nursing services outside the hospital.

Resolutions from the Private Duty Section to the Canadian Nurses Association are:

In as much as, under present conditions, about 1,700 nurses are being graduated each year from Canadian training schools, and in as much as this number of nurses cannot possibly be absorbed for nursing service in the community, therefore resulting in serious unemployment under normal conditions, and under present conditions creating a critical condition of acute want with many nurses; be it resolved that, in each incoming class, the number of students enrolled be reduced, and these vacancies supplied by the employment of graduate nurse service. In addition to this, that in the future extension of hospital services, the necessary nursing service, be organised by the employment of graduate nurse staff.

It is recommended that this resolution be sent to hospitals of not less than 150 beds.

Resolved, that the Private Duty Section of the Canadian Nurses Association go on record as endorsing the plan recommended in the Weir Report of compulsory registration of all who care for the sick for hire.

It is recommended that this resolution be presented at the General Meeting, Friday afternoon.

Public Health Section

The meetings of the Public Health Section during the last two days have been well attended by representative members of the nine provinces. Papers presented on Education of the Public Health Nurse, Supervisors, and Supply and Demand brought forth interesting and stimulating discussions.

A summarised report of the work of the Section and developments in the provinces was presented by the Secretary. Much interesting informa-

tion was contained in this report: we learn that 1,000 nurses are engaged in public health work throughout Canada and interesting progress has been made.

Summer courses and institutes have been organised in the provinces of British Columbia, Saskatchewan, Manitoba, Ontario and Nova Scotia; Ontario has had, in addition, institutes on maternal care.

Quebec reports a large increase of nurses in city and health departments and the extension of the Grancher system of placing tuberculous children in country foster homes, to include English as well as French children.

Nutritionists have been appointed to the staffs of the C.W.A. and V.O.N. in Montreal, and a nurse psychiatric social worker has been applied to the health service of Montreal Child and Social Agencies. A commissioner, appointed by the Secretary of Quebec, has been studying the health and unemployment question during the last year.

Saskatchewan reports a Cancer Commission and the appointment of a Commissioner of Mental Health; also free sanatorium treatment and consultant clinics for tuberculosis.

Prince Edward Island reports the organisation of a Provincial Department of Health: this taking over the public health services so ably demonstrated in that province by the Canadian Red Cross.

Ontario reports provincial and municipal campaigns for giving of toxoid, establishment of mental health clinics, travelling dental car equipped by the I.O.D.E. for remote areas, intensive efforts to combat tuberculosis. I refer to the valuable services of the Canadian Red Cross in isolated areas.

All provincial sections in Canada are planning to study intensively the Survey during this coming winter.

Record was made that the by-laws of the Section be revised and that the

summarised report of the Secretary be mimeographed and sent to each of the provinces. There were four resolutions adopted to be sent on to the C.N.A. in general session. (See page 490).

Nursing Education Section

The following is a brief report of the activities of the Nursing Education Section during the past two-year period, and the findings during sessions held on Thursday and Friday of this convention week.

During 1930 an endeavour to ascertain the feelings of the various provincial sections (N.E.) with regard to the admission of Orientals, Canadian-born, into nursing schools in Canada was made, with the result that opinions differed considerably in this regard. During the first meeting of this Section, held on Thursday last, after considerable discussion, it was decided that any Canadian-born member of Oriental or European families, possessing the necessary qualifications should be considered eligible for admission to Canadian schools of nursing. It was further recorded that many schools throughout Canada are already graduating nurses who are members of European families, while one reports the acceptance of Canadian-born Oriental students.

Several hundred copies (reprint) of the report of the Committee on Nursing Education, I.C.N., were forwarded to the Chairmen, Provincial Nursing Education Sections, for distribution and consideration.

During 1930-1931 a special committee was formed and a proposed minimum curriculum for use in schools of nursing prepared by them and presented for discussion and consideration, the context having been published in various numbers of *The Canadian Nurse* and copies loaned to nurse teachers upon request.

All Provincial Nursing Education Sections have been represented during these sessions, and interesting reports presented by them.

During a round table discussion on "The Curriculum in Canadian Schools of Nursing, and Re-adjustment in the Educational Programme," at which Professor F. Clarke was the speaker, contributions through the medium of very excellent papers were made by members of seven provincial N.E. Sections.

During the second round table on "A Discussion of the Survey Report from the Educational Angle, Dealing with Recommendations Affecting Training Schools," which discussion was introduced by Miss Marion Lindeburgh, further contributions were added from Quebec N.E. Section.

The appointing of a Standing Committee on Curriculum was referred to the incoming Executive Committee.

Two resolutions have been forwarded from the Section to the C.N.A. regarding:

(a) The reduction of students in schools and the increase in graduate staff.

(b) Re the advisability of schools in the United States of America accepting Canadian applicants, knowing beforehand whether or not such applicants would be admitted to the country under existing immigration laws.

Officers Elected

President, Miss F. H. M. Emory^①; First Vice-President, Miss R. M. Simpson; Second Vice-President, Miss G. M. Bennett^①; Honorary Secretary, Miss Nora Moore^①; Honorary Treasurer, Miss M. Murdoch.

Private Duty Section: Miss I. MacIntosh^①; Vice-Chairman, Miss Mabel McMullen; Secretary-Treasurer, Mrs. Rose Hess.

Nursing Education Section: Chairman, Miss G. M. Fairley^①; Vice-Chairman, Miss M. F. Gray; Secretary, Miss E. F. Upton^①; Treasurer (to be elected).

Public Health Section: Chairman, Miss M. Moag^①; Vice-Chairman, Miss M. Kerr; Secretary-Treasurer, Mrs. I. Manson Prince^①.

^① Re-elected.

The Banquet

Arrangements for the banquet were admirably carried out under the direction of the New Brunswick Association of Registered Nurses in co-operation with the hotel management. Three hundred and forty attended this function, at which the after-dinner speaker was Roy Fraser, Professor of Biology and Bacteriology, Mount Allison University, Sackville, N.B.

Professor Fraser was introduced by Miss H. Dykeman, of Saint John. His subject was "The Scientist and the Survey Report." Miss G. M. Bennett, Second Vice-President, thanked the speaker of the evening, her motion being seconded by Miss M. K. Holt, of Montreal.

The address by Professor Fraser and those by Professor Clarke and Dr. Stewart Cameron were published in the August number of the Journal. Mr. Massey's address was put into printed form during convention week.

REPORT OF THE HONORARY SECRETARY

Since the last General Meeting, in 1930, nine executive meetings have been held, with an average attendance of seven members. The meetings have been held in the Club Room of the Royal York Hotel, commencing at 12.00 o'clock noon, and usually concluding at 5.00 o'clock.

Members of the Executive Committee, in addition to those who reside in or near Toronto who were able to attend one or more meetings of the Committee, were: Miss K. W. Ellis, First Vice-President; Miss G. M. Bennett, Second Vice-President; Miss Margaret Moag, Chairman, Public Health Section; Miss M. K. Holt, President, A.R.N. Quebec; and Miss G. M. Watson, Chairman, Nursing Education Section, Saskatchewan R.N.A.

At the first meeting, held in September, 1930, no reports were received from any of the Provincial Associations. At the Executive Meeting held in April,

1932, the Executive noted with satisfaction that reports had been received from Alberta, British Columbia, Manitoba, New Brunswick, Ontario, Quebec and Saskatchewan. It is anticipated in the next two-year interval that all Provincial Associations will submit interim reports to the Executive Committee.

In September, 1930, the President was elected convener of the Programme Committee. Copy of the programme for this meeting shows that much time and thought have been expended on it.

During the years 1930-1932, the Executive found it necessary to form the following committees to deal with the business arising from the correspondence: Committee to Study the Use of Films for Educational Purposes; Committee on the Comparative Cost of the National Office and the Publication of *The Canadian Nurse* in Eastern and Western Canada; Committee to Study Group Nursing; Committee on Post-Convention Tours; Membership Campaign Committee; Programme Committee to Arrange Suggested Topics, etc., for the International Council of Nurses Congress in Paris; Committee to Study the Need of a Religious Guild; Committee on the Pooling of Expenses; Committee on the Possibilities of the Nursing Profession for a Handbook on Vocational Guidance; Committee to Arrange for a Joint Booth of *The Canadian Nurse* and the *American Journal of Nursing* at the American Hospitals Association Meeting in September, 1931; Committee to Study the Use of the Figure of a Nurse in Non-Professional Advertisements.

A great deal of time has been devoted at each Executive meeting to the reports received from the Joint Study Committee, also to the formulation of plans which would be of value to the Provincial Associations in interpreting the Report of the Survey of Nursing Education in Canada to the medical and nursing professions and to the community at large. Ways and means were suggested, too, to help the Provincial Associations with the distribution, publicity and sale of the Report.

Before closing, may I thank the President and the Executive Secretary for their help and co-operation on every occasion, and the other members of the Executive for their loyal support at all times. All of which is respectfully submitted.

(Signed) NORA MOORE,
Honorary Secretary.

REPORT OF THE EXECUTIVE SECRETARY

I have the honour to submit the fifth biennial report as Executive Secretary, which must follow previous reports in relation to content, since the activities of the National Office have been similar throughout each period.

Executive Committee—The Executive Committee consists of Officers (5), Councillors (36), and Chairmen of Sections (3), or 44 altogether. The members of the Committee are advised in advance of all meetings. These meetings are held quarterly, usually in the city in which the President resides. During the period 1930-32, one special and nine regular meetings were held, with an average attendance of seven members.

All business relating to the Association receives the attention of the Executive. To each meeting are submitted detailed reports, including monthly financial statements from the Executive Secretary of the C.N.A. and the Editor and Business Manager of *The Canadian Nurse*, from Standing and Special Committees, National Sections and Provincial Associations. Members of the Executive are indebted to the Honorary Secretary for the elaboration upon numerous subjects in the minutes of these meetings—copies of which are sent from the National Office to all members.

During the past two years the Councillors have been kept well informed in regard to progress of the various Special Committees. In this way the Provincial Associations should be cognisant of whatever developments are made or conclusions reached in the interim between General Meetings.

Probably the development of the C.N.A. can be explained more readily by reporting that the cost of each Executive Meeting is now almost three times that of those held in the early years following the appointment of an Executive Secretary.

Special Committees—A larger number of Special Committees have been active in the past two-year period than at any previous time in the history of the C.N.A. Special Committees newly formed in 1930 were: Comparative Costs; Exchange of Nurses; History of Nursing; Registries; Films for Educational Purposes.

Committees functioning previous to 1930 and continuing with the same personnel are: Joint Study; Red Cross Enrolment; Crest. Members of the former Memorial Committee acted in having the Crest engraved on the Memorial Panel.

Committees appointed following June, 1930, are:

Group Nursing — Formation and function of this committee did not extend beyond the appointment of a convener. After being referred to several Executive Committee meetings it was decided that action relative to appointment of a committee to study Group Nursing be left in abeyance until after the General Meeting in 1932, since Dr. Weir in his Survey discusses this subject at length.

In September, 1930, the Executive Committee was asked to express opinion relative to Canadian-born Chinese and Japanese youngwomen being accepted as students in schools of nursing. The Chairman of the Nursing Education Section was requested to obtain opinion by referring this question to the Provincial Sections. From a summary prepared from seven replies it was apparent that hospitals were not willing to accept these students, and no suggestions were made as to a solution of the problem.

In December, 1930, the Executive was requested by the National Girls' Work Board of the Religious Educational Council to have prepared a short memorandum on the possibilities of the Nursing Profession for a Handbook

on Vocations which was to be published by the Board. Miss Beatrice Ellis was asked to convene a special committee for the purpose of preparing this memorandum. Following collection and collation the material was referred to the Nursing Education Section for approval and suggestions, after which the President sent the memorandum to the Girls' Work Board.

In April, 1932, a committee was appointed to enquire into the use of the figure of the nurse in non-professional advertisements.

This report makes only brief reference to the work of the committees, as reports by the conveners will be presented later. A greatly increased amount of clerical work in the progress of special committees has been done at headquarters in the past two-year period.

Federated Associations — Of these brief mention only will be made here, as each provincial association will present a report, made according to an outline suggested by the Executive.

The provincial secretaries have been most appreciative of the complimentary copies of Executive Committee Meetings. It was not possible to follow this procedure as long as there was a large number of organisations in affiliation. Copies of progress reports of several special committees were supplied these associations. Notes of interest in relation to the Provincial Associations are:

1. All provinces except two now require annual re-registration for a nurse to continue in good standing.

2. Annual scholarships are offered by four associations, one of which makes two awards.

3. The educational standard of admission has been raised.

4. Institutes for nurses for periods extending from three days to two weeks have been arranged under the auspices of these associations.

5. Eight associations engage a nurse on salary as secretary-treasurer and registrar and provide office accommodation.

Re-Organisation Procedure—In accordance with legal advice obtained relative to a Form of Consent for signature of the President and Secretary of all federated organisations, forms were sent on August 5, 1930. All organisations in federation previous to June, 1930, were notified of the decision reached at the General Meeting, whereby membership in the C.N.A. was limited henceforth to the nine provincial associations of registered nurses. Later there was printed a supply of the revised Constitution and By-laws.

Membership—Following reorganisation in 1930 there was a marked decrease in C.N.A. membership; however, the year 1931 showed an increase amounting to 601 members, or 6.96% over total membership of provincial associations in 1930. This increase is encouraging, especially under general conditions, and indicates a realisation towards numerical strength in the provincial associations when they constitute the membership of the national organisation. Congratulations are extended to the hostess organisation, the Association of Registered Nurses of New Brunswick, for achieving the encouraging increase of 25% in membership in 1932 compared with 1931.

Nominations—Forms were duly forwarded to the Provincial Associations for the nominations of officers. From the completed forms a ticket of nomination showing the two highest nominees for each office was prepared, copies of which were sent to the federated associations and the Executive Committee.

International Council of Nurses—A meeting of the Board of Directors, I.C.N., was held in Geneva from June 29 to July 1, 1931. The decision of the Executive, C.N.A., was that it would be impossible for the C.N.A. to undertake to send a representative to that meeting owing to the expense involved. A brief report of the proceedings prepared from a copy of the minutes received was prepared and published in the *Journal*, September, 1931.

The President, C.N.A., has been appointed to the Florence Nightingale

Memorial Committee. Miss Mabel Gray is also a member of this Committee, of which Mrs. Bedford Fenwick is chairman. Miss E. K. Russell was appointed to the chairmanship of the Sub-Committee on University Relations, I.C.N.

Questionnaires from International Headquarters completed and returned related to: State Supervision of the Practice of Nursing; Public Health Nursing; Nursing Education; and Nursing Practice. The assistance of the provincial secretaries and the Nursing Education Section was sought in compiling replies for these questionnaires.

To assist in having complete volumes of the *Journal* at Geneva, 76 copies of back numbers were forwarded during 1931 from National Office. There are still a few missing copies required.

For the September, 1931, meeting of the Executive Committee a report was submitted relative to transportation facilities for Canadian nurses attending the I.C.N. Congress, 1933. Copies of this report were sent later to the Provincial Associations.

Other Organisations in which the C.N.A. has had Representation—The C.N.A. has been represented officially with: The National Council of Women of Canada; The Canadian Council on Child and Family Welfare, and on the sub-committee of the Child Hygiene Section of the Council; The Central Board of the Victorian Order of Nurses for Canada; The Placement Bureau of the Canadian Association of Social Workers; The Canadian Social Hygiene Council; The Programme Committee, American Hospital Association; The Made-in-Canada Fair; The Dominion Fire Convention.

Memorial Panel—As has been customary since 1926, floral tributes were placed annually before the Memorial Panel on Armistice Day. Miss Gertude Garvin, of Ottawa, very kindly does this for the Association. With Miss Garvin's assistance, arrangements were made to have the Panel cleaned previous to November 11, 1932. Mr. G. W. Hill, sculptor, gave the cleaning his personal supervision,

and through the interest of the Sergeant-at-Arms, the Minister of Public Works has promised that an annual cleaning in future will receive the attention of that Department. It is reported that the cleaning last autumn restored the Panel to its original exquisite beauty. When the Registered Nurses Association of Ontario met in Ottawa in April, 1932, a visit was made to the Memorial and a wreath placed by the President of that Association.

Publications—A tabulation of the summary of the report made by the committee appointed by the Nursing Education Section to study nursing standards was prepared for publication in the *Journal*, reprints mailed from the National Office, were sent to 200 superintendents of nurses in Canada with the compliments of the Section.

Reprints of a chart showing the membership of the C.N.A. which was reproduced in the *Journal* were supplied to the Provincial Associations.

Reprints of Laws and Regulations Governing the Registration of Nurses in the Provinces of the Dominion of Canada as published in the *Journal* were made available for distribution.

The Brief History of the Canadian Nurses Association from time of organisation to June, 1924, should be brought up to date, or a record in some other form prepared for reference and information. Experience has shown that there should be compiled in mimeographed form (a) an outline of the policies of the C.N.A. available to the officers who receive appointment to the Executive without possessing a familiar background of national organisation; (b) a manual defining the relationship of the Councillors to the National Executive and to the Provincial Associations which they represent; (c) a similar pamphlet in connection with the Sections and Provincial Secretaries. These requirements have not received attention owing to the Executive Secretary being able to give only part time to the activities and interests of the organisation.

Visitors to National Office—Groups of nurses receiving what may be termed peripatetic teaching in public health nursing under the direction of the Department of Public Health Nursing in Manitoba, visited the National Office, where an hour or more was spent in explaining the national organisation and the scheme of carrying on the work.

The Chairman and Secretary of the Joint Study Committee were among those who called at headquarters; others were the First Vice-President and the Honorary Treasurer, C.N.A. It is regretted that all officers and councillors cannot visit the National Office more frequently, as in that way they might obtain an insight into requirements and activities which have been conveyed in written reports.

The Survey Report—Complimentary copies of the Report were sent by the C.N.A. to eighteen individuals in Canada and other countries. A supply is kept at headquarters for filling orders received outside the Province of Manitoba.

Placement Bureau—Requests for assistance in obtaining positions came not alone from nurses in Canada and several other English-speaking countries, but also from a number of European countries. Due to the serious unemployment among our nurses, a great sense of helplessness was experienced when making reply to this type of letter.

Decennial Census — The Federal Bureau of Vital Statistics was requested to classify nurses in the Decennial Census of 1931 as Graduate Nurses and Non-Graduate (or Practical). A request has been made for this information when available. (Not before December, 1932.)

Correspondence — Approximately 12,000 pieces of mail are handled annually.

A large portion of correspondence is between the Federated Associations, the Sections, the Executive Committee, Conveners of Committees and Headquarters.

Correspondence relates to a multitude of subjects. Frequently replies to

inquiry for information require several hours research. Requests are received from the International Council of Nurses, National Organisations of Nurses in other countries, organisations in Canada and other countries interested in the promotion of health and prevention of disease. Numerous individuals refer for information relative to registration and registration examinations, post-graduate education for nurses, hospitals and schools of nursing, History of Nursing in Canada, also relative to nursing conditions and nurses in other countries.

An ambition at headquarters is the preparation of a folio which will contain a standard type of reply in supplying information on subjects for which enquiries are most frequently received. When once prepared, revision and enlargement of this folio should be readily done.

In August, 1930, 375 letters were mailed to the Secretaries of Hospital Boards of Trustees and Superintendents of Schools of Nursing. These letters contained copies of resolutions from the Private Duty and Nursing Education Sections relating to means whereby unemployment of nurses might be relieved.

Reports of the proceedings of the General Meeting, 1930, were sent to the National Council of Women of Canada; the Canadian Council on Child and Family Welfare and the Editor of *The Canadian Hospital*.

Staff—At the close of the last general meeting the Executive decided that an assistant with journalistic ability and preferably a nurse should be appointed provisionally until such time as the Executive Secretary should be relieved of the duties as Editor and Business Manager.

Following four months in unsuccessful attempts to find a nurse with necessary qualifications and who was free to become attached to National Office, the Executive approved the appointment of a junior stenographer to be employed when necessary. During the first eighteen months the National Office was in operation the staff consisted of the Executive Secret-

ary alone. Following the removal of the *Journal* to Winnipeg, a stenographer was appointed, and two years later a bookkeeper with stenographic ability was added to the staff. The Executive Secretary and bookkeeper have continued since first appointed. Several changes have been made in stenographers. Since June, 1931, a nurse recently graduated and with three years' stenographic experience has been engaged. The junior stenographer has been employed at intervals for a period totalling nine months.

On September 25, 1930, the Executive reappointed the Executive Secretary, Editor and Business Manager of the *Journal*, to serve until such time as a full- or part-time Editor can be appointed. Previously the reappointment of the Executive Secretary as Editor was made annually. The dual responsibilities of these two offices have been delegated to the Executive Secretary since September, 1924.

Close association in the administration of the National Office for over nine years is regarded as sufficient license for me to express briefly to the C.N.A. members my admiration for the always evident, excellent high professional calibre and the magnificent type of womanhood existent in the membership. The majority of the members are never personally known to more than those in their local groups and districts—these are the members

who make it possible for those nurses in each province, gifted with leadership, to achieve for the C.N.A. its enviable position as a most workable democratic organisation, to have put through to successful completion several undertakings of tremendous magnitude, and to maintain cordial international and inter-provincial relationships.

The office of president has been held by five members since the National Office was opened. Over 200 members have served as officers and councillors and have assisted the President in directing C.N.A. interests between general meetings. To all of these and especially to the Presidents, and also to the Provincial Secretaries, I acknowledge most sincere gratitude for the assistance given me, and for the always evident toleration towards errors and omissions which have occurred, sometimes, at headquarters.

To the membership at large, may I stress the joy it has been for me to have had a small part in contributing thus far toward the development of our national organisation, and to express my thanks for the unfailing support and good-will that has made it possible for a National Office for nurses in Canada to function.

Respectfully submitted,

(Sgd.) JEAN S. WILSON,
Executive Secretary.

Reports of Standing Committees

ARRANGEMENTS COMMITTEE

In co-operation with the Management of the Admiral Beatty Hotel, the Arrangements Committee has been able to provide accommodation in the Hotel for the C.N.A. General Meeting, 1932.

Social functions for the week are:

Tuesday, June 21st

4.30 p.m.—Receptions at the Saint Joseph's Hospital and the Saint John Tuberculosis Hospital, to which all visiting nurses are invited.

Wednesday, June 22nd

4.30 p.m.—A drive for all visiting nurses. Tea at the Riverside Golf and Country Club for the Executive and official delegates.

7.30 p.m.—Banquet.

Thursday, June 23rd

4.30 p.m.—Sail on the Saint John River, with beach picnic at Sand Point. Every person is invited.

Friday, June 24th

4.30 p.m.—Tea at the Saint John General Hospital (guests of the Women's Hospital Aid).

Members of the Committee are: Misses M. Murdoch, M. E. Retallick, B. B. Howe, H. Dykeman, E. Henderson, M. Downing, F. Coleman, and Mrs. G. VanDorsser.

(Sgd.) MARGARET MURDOCH,
Convener.

PROGRAMME COMMITTEE

Your committee consists of Miss Grace Fairley, Miss Isobel MacIntosh and Miss Margaret Moag, conveners of national sections, Miss Margaret Murdoch, Convener of Arrangements Committee, Miss Nora Moore, Honorary Secretary, Canadian Nurses Association, and Miss Florence H. M. Emory, Convener.

With the programme already in your hands the committee gives account of

its stewardship. Three aspects are accentuated:

(1) The programme has been built around the Report of the Survey of Nursing Education in Canada. That is true of the addresses of guest speakers, of the content of open sessions and of section meetings.

(2) Through the medium of Provincial Associations, wide distribution has been given the programme and that with a view to increased attendance at this biennial meeting.

(3) The committee records indebtedness to the nurse members of the Joint Study Committee for suggestions and guidance in the preparation of the programme, and the Arrangements Committee in facilitating plans for the meeting.

On behalf of the Committee,

(Sgd.) FLORENCE H. M. EMORY,
Convener.

PUBLICATIONS COMMITTEE

This Committee has but three members, Miss Jean E. Browne, Miss Jean S. Wilson, Editor and Business Manager of *The Canadian Nurse*, and Florence H. M. Emory, Convener. Throughout the two-year period, the Committee has felt that it might best function in giving assistance to the Editor of *The Canadian Nurse* along certain well-defined lines:

1. Through guidance and advice relative to policies and general content.

2. Through suggestions regarding prospective contributors: (a) Cultural topics of professional interest; (b) Developments in nursing at home and abroad; (c) Procedures and techniques in current nursing practice; (d) Editorials and book reviews.

Your Committee supports the Committee on Comparative Costs and the Executive of the Association in recommending:

1. That an Editor be appointed for *The Canadian Nurse*, dating from January 1, 1933.

2. That the office of the Executive Secretary of the Canadian Nurses Association and the Editor and Business Manager of *The Canadian Nurse* be adjacent (if possible), and that they be under separate management.

Further, the Committee wishes to record appreciation of the services of

the Editor and Business Manager of the *Journal*, arduous as they have been in addition to the duties of Executive Secretary of the Canadian Nurses Association.

On behalf of the members of the Committee.

(Sgd.) FLORENCE H. M. EMORY,
Convener.

Reports of Special Committees

THE JOINT STUDY COMMITTEE

The Joint Study Committee of the Canadian Nurses Association and the Canadian Medical Association was organised in the summer of 1927 for the purpose of considering the position of the nursing profession in Canada and, if deemed advisable and practicable, to conduct a Survey that would be national in its scope. By November, 1929, the organisation of the study was advanced to a point where Dr. Weir, Chief of the Department of Education in the University of British Columbia, assumed charge as Director. At previous biennial meetings of this Association, interim reports have been presented, indicating the progress that was being made.

Late in the autumn of 1931, the Report was completed and placed in the hands of the University Press of Toronto for publication. The Committee was able to make very satisfactory arrangements with the University for the printing and distribution of the Survey. An edition of 3,000 copies was contracted for, and these were off the press by the middle of February, 1932. The price for individual copies was placed at \$2.00, and in quantities of ten or more a charge of \$1.75 was made. On May 9th, when this report was made out, 2,067 copies had been disposed of.

While the Survey was a national undertaking, any application of the findings will be largely a matter for provincial consideration. That being the case, it was felt that a Joint Study Committee should be organised in each

province, to be composed of representatives from the nursing and medical professions and the Hospitals Association, and that this group should select two or three lay members, possibly from pedagogic and social service interests.

The Committee trusts that this Association will approve of its actions, and, further, that the C.N.A. will accept the recommendation that the Committee be continued for such time as may be necessary to carry through to completion whatever plans may be finally adopted both federally and provincially.

The Report of the Survey of Nursing Education in Canada, a copy of which is here submitted, is a volume of nearly six hundred pages. It is factual to a greater degree, perhaps, than most similar reports, because the Director has actually visited scores of hospitals, training schools and social organisations interested in welfare work, and so was able to secure his information at first hand. This, together with the returns from many questionnaires, placed him in a position to present a fair picture of the problems upon which he was asked to report.

The recommendations are the result of a study of these facts in the light of the knowledge of sociology and education possessed by the Director, and today represents his considered opinion.

All of which is respectfully submitted.

(Sgd.) JEAN E. BROWNE,
Secretary.

COMMITTEE ON THE HISTORY OF NURSING IN CANADA

The report of the work of the two years can be summarised as follows:

It appears that a publication in book form concerning the history of nursing in Canada is needed. Also it is felt that a book dealing with this subject would have a good sale.

The Provincial Nurses Associations were asked for their opinion regarding the matter. The replies from some were non-committal, but at least five of the Associations have expressed a definite interest.

The Committee has conferred with one publishing house (Messrs. J. M. Dent and Sons) and have had the opinion from them that a book of this kind would be considered a good business proposition. For this reason this firm would be willing to undertake the responsibility for the book under certain conditions and with certain co-operation from the Canadian Nurses Association. If the Canadian Nurses Association would guarantee the sale of 2,000 copies, the work could be undertaken without cost to the Association. This was the attitude of this firm a year ago; the matter has not been discussed recently.

Regarding authorship, there is a strong feeling that the writer should be an experienced student of history and also a writer of recognised ability.

The Province of Quebec has spoken very decidedly in favour of having the book written by a nurse if possible, and has suggested the names of two nurses for consideration.

The recommendations of the Committee are as follows:

1. That the C.N.A. should take such action as is necessary to secure the writing and publication of a history of nursing in Canada.

2. That the C.N.A. should do this only when it is assured that a book of lasting worth is being produced. The book should have merit and distinction from the literary standpoint; it should also have merit and distinction among the historical publications of the country.

(Sgd.) E. KATHLEEN RUSSELL.
Convener.

COMMITTEE ON COMPLETION OF NATIONAL MEMORIAL

Following the adoption of a design for a Crest for the Canadian Nurses Association in June, 1930, the Convener of the former National Memorial Committee was asked to convene former members as necessary to undertake having the Crest engraved on the Memorial Panel in the Hall of Fame, Parliament Buildings, at Ottawa.

The former sculptor and architect were consulted, and permission obtained from the Federal Department of Public Works for the work to be done.

A plaster model from the design chosen was made and approved, previous to the Crest being engraved, under the direction of the Architect.

The total cost of completing the Memorial Panel amounted to \$345.00.

(Sgd.) JEAN I. GUNN,
Convener.

COMMITTEE ON THE ENROLMENT OF NURSES FOR EMERGENCY SERVICE

In reporting on the Enrolment of Nurses for Emergency Service, it might be well to repeat a short historical outline of this movement.

At the general meeting held in Ottawa in August, 1926, the following motion sent to the meeting by the Registered Nurses Association of Ontario, was on the agenda:

"THAT the Canadian Nurses Association approach the Canadian Red Cross with the recommendation that the Canadian Red Cross negotiate with the Federal Government to bring about a system of enrolment from which nurses would be appointed to military service when needed, and from which they might be called upon for emergency work in time of any national or provincial disaster."

After considerable discussion the following resolution was passed:

"THAT a conference be arranged between the C.N.A., the Federal Government and the Canadian Red

Cross Society to discuss the question of such an enrolment."

This conference was arranged in Ottawa, and the following letter was received by the President of the C.N.A. from Colonel Jacques:

"With reference to the Conference which took place in the office of the Director-General of Medical Services at which, in addition to yourself, Doctor Biggar (Chief Commissioner of the Canadian Red Cross Society), the Director-General of Medical Services and the Deputy Director-General of Medical Services, were present:

"I am now authorised to inform you that the scheme laid down at this Conference has the full endorsement of the Department of National Defence.

"When this work has been carried out, I feel personally a great deal will have been accomplished and, should an emergency arise at any time in the future, the question of organisation of the Nursing Services will be very much advanced by this plan."

Following this, a Joint Enrolment committee, composed of three representatives of the C.N.A. and the Canadian Red Cross Society, was organised, and a practical scheme of enrolment was worked out. It was agreed that Provincial Nurses Associations should carry out the actual enrolment on a form adopted by the National Joint Committee, and that they would transmit the completed enrolment forms to the provincial offices of the Red Cross, where the names, addresses and other details regarding each enrolled nurse would be recorded. In order to carry the actual work of enrolment into effect, it was recommended that there be a provincial joint enrolment committee in each province, with equal representation from the Provincial Nurses Association and the provincial divisions of the Canadian Red Cross.

Copies of the regulations and application forms have been sent to each Provincial Nurses Association and should be available to all members.

The enrolment now stands as follows:

British Columbia	300
Alberta	52
Saskatchewan	30
Manitoba	42
Ontario	298
Quebec	54
New Brunswick	31
Nova Scotia	40
Prince Edward Island	10
Outside of Canada	19

876

In conclusion, I wish to point out that, in my opinion, the time has come for a change in the convener of the representatives of the C.N.A. on the National Joint Enrolment Committee. I have served in this capacity from the beginning of the Committee in 1926, until the present time, and I beg now to make the recommendation to the in-coming Executive that the President of the Canadian Nurses Association should act ex-officio in this capacity. By this means, there will be a closer link between the National Joint Enrolment Committee and the Association.

(Sgd.) JEAN E. BROWNE,
Convener.

COMMITTEE ON REGISTRIES

Following the discussion on the national organisation of Registries at the Biennial Meeting of the Private Duty Section, C.N.A., June 27, 1930, in Regina, this Section recommended the appointment of a national committee on Registries. The function of this committee was to investigate and report all problems directly associated with the employment and professional discipline of private duty nurses.

This recommendation was favourably accepted by the C.N.A. on June 28th.

The personnel of the Committee appointed represented the three sections of the C.N.A. and the chairman of the Private Duty Section was appointed convener of the Committee.

The first meeting was held at Toronto in November, 1930, where it was unanimously decided that pro-

vincial help should be requested in the form of representative sub-committees.

The request from the National Committee was graciously acknowledged by each Province and sub-committees were formed.

At the second meeting, which was held in Toronto on May 27, 1931, the Committee drew up a form of questionnaire which was sent to each member of the Committee in the various Provinces, also to the Secretary of each Provincial Association asking for their assistance and co-operation.

Information Asked From the Provincial Committees

Registries:

1. (a) How many professional registries have you in your Province and where located?
- (b) What hospitals in your Province function as registries, and where located?
2. (a) Secure copy of rules and regulations, constitution and by-laws controlling each registry.
- (b) Indicate the number unable to supply printed rules and regulations.

Administration:

- (a) Location of office, i.e., office building, private home, etc.
- (b) Personnel employed; professional qualifications of Registrar.
- (c) Salaries.
- (d) Fee paid by Registrant.
- (e) Average annual income and average annual expenditure.
- (f) How often does the Governing Board of the Registry meet?

Registrants:

- (a) Professional qualifications. Are registrants required to be registered annually in the Province?
- (b) Approximate number.
- (c) Types of service: 24-hour, 12-hour, hourly nursing, etc.
- (d) What percentage of calls are for hospital service? What percentage for home service?
- (e) Approximate daily average number of nurses unemployed during the months from September, 1930, until June, 1931.

(f) What registries in the Province include undergraduates, practical nurses or attendants?

(g) What responsibility does the Registry assume for the supervision of their work?

Records: What records are kept?

Note.—In the registries or hospitals that have no printed constitution, by-laws and regulations, a statement would be appreciated as to how the registry is conducted and governed, with special reference to the Governing Board.

A splendid response was made by the Provinces, and at a meeting in November, 1931, their information was received with great interest. The Committee agreed to request the Executive of the C.N.A. to have their information tabulated at the National Office.

Not enough praise can be given the National Office staff for the clear and concise manner in which this information has been tabulated and will for all time be a record of Registries as they existed in Canada during the years 1930 and 1931.

The fourth and last meeting of the Committee was held in Toronto on May 21, 1932, when suggested recommendations were made:

1. The methods of keeping records by registries even in small places should be improved, and

2. The recommendations in Chapter IX of the Survey of Nursing Education in Canada were endorsed as follows:

(a) So-called "Practical Nurses" and all who care for the sick for hire should be licensed and brought under control and supervision;

(b) Reliable data on the services of the nurse, based on carefully analyzed reports of patients, doctors and nurses should be kept in the Registrar's office;

(c) The consolidation and control of nursing registries under the general conditions stated in Section 7 of the context is recommended.

(Sgd.) ISABEL M. MACINTOSH,
Convener.

COMMITTEE ON EXCHANGE OF NURSES

The Committee on the Exchange of Nurses which you asked me to convene is constituted as follows: Misses Kathleen Ellis; Jean Gunn, Ruby Hamilton, Mabel Hersey, Mabel Holt, Nora Moore, Isabel Manson Prince, Kathleen Russell, and Jean Browne (Convener).

The first work of the Committee was to draw up a memorandum on the purposes of the Exchange, and practical considerations in connection with working it out. A copy of this memorandum is attached.

The memorandum drawn up by the Committee at its first meeting in the autumn of 1930 was submitted to the Executive of the Canadian Nurses Association and approved. At the request of the President, the Chairman of the Committee wrote to the following associations, enclosing the memorandum and asking for consideration of an exchange of nurses with Canada: The American Nurses' Association; the National Council of Trained Nurses of the Irish Free State; the Australian Nursing Federation; the College of Nursing, England; the South African Trained Nurses' Association; the New Zealand Trained Nurses' Association.

Replies were received from all of these, but the only one that actually acted on your Committee's proposal was the College of Nursing, England. After a good deal of correspondence with Miss Hester Parsons, Director of Education of the College of Nursing, it was decided, both by your Committee and the College of Nursing, that, for the time being, it would be better to work out a scholarship scheme rather than the original idea of exchange.

The following memorandum in regard to the scholarship scheme was drawn up by your Committee and agreed to by the College of Nursing:

(1) That the scholarship should extend over a period of at least six months;

(2) That the Committee should take no responsibility in connection with financing travelling expenses;

(3) The scholarship nurse would not receive a salary and would have no executive obligations in the hospital to which she went. She would, however, be expected to give her services in return for educational advantages.

It was decided to try this out as an experiment at first. The first Canadian nurses to participate in this scheme are Miss Norena MacKenzie, from the Montreal General Hospital, and Miss Eileen Flanagan from the Royal Victoria, Montreal. These nurses begin their six months' scholarship in England on July 23rd next. In a general way, the following is an outline of the course they will follow:

(1) Two months in St. Thomas's Hospital to observe the teaching of the preliminary classes and to follow the whole teaching outline for two months, at the same time getting an idea of teaching procedures in the Junior, Intermediate and Senior classes, and seeing as much practical ward work as possible, and also the work in the Out-Patient Department.

(2) Four months in Guy's Hospital, following much the same routine as in St. Thomas's.

(3) Opportunity to attend as many lectures as possible, both in the hospitals and in outside courses, especially in the Red Cross International Course at Bedford College.

Plans are being made by the College of Nursing to send nurses to Canada on a reciprocal scheme, but so far these plans are not sufficiently definite to report on.

Your Committee is extremely grateful to the Education Department of the College of Nursing, and especially to Miss Parsons, the Director, for all the trouble that has been taken in completing these plans. The last sentence in her last letter is indicative of the splendid co-operation that we have received throughout a year and a half of negotiations: "We can assure your Committee that we will do everything in our power to make their visit (referring to the two Canadian nurses) a successful one."

(Sgd.) JEAN E. BROWNE,
Convener.

MEMORANDUM

I. *The Purpose of the Exchange:*

(a) The dissemination of the best in the practice and methods of nursing.

(b) The promotion of international friendliness and understanding.

II. *First Steps in Its Operation:*

It should at first be limited to an exchange of nurses on the staff of Schools of Nursing, for the following reasons:

(a) The contacts made will influence a larger group.

(b) The financial arrangements will be simpler, since board and lodging will be arranged for.

(c) More control can be exercised in the School than elsewhere.

III. *Countries with whom to Exchange:*

To commence with, only English-speaking countries should be asked to co-operate in this plan. This will obviate language and other difficulties.

IV. *Type of Schools:*

To begin with, only those schools that conform to the following requirements should participate in the exchange:

(a) associated with a hospital of at least 200 beds;

(b) having one or more instructors of nurses with a certificate from a University course;

(c) situated in a centre that offers general educational facilities for nurses.

V. *Length of Time of Exchange:*

The exchange should be from ten to twelve months, the exact time to be fixed at the pleasure of the schools involved in the exchange.

VI. *Financial Considerations:*

(a) The Exchange Committee can take no responsibility for travelling expenses. Travelling expenses must be provided by the individual exchange nurse, by bursaries from the Schools participating, or by nurses' organisations.

(b) The exchange nurse is to receive the salary of the position to which she goes.

In drafting these recommendations, the Committee has had in mind the necessity of making the initial experiment on the safest and simplest possible basis, and as free as can be from complicating factors that might constitute serious international problems. After the initial experiments, when a certain body of experience has been gained, it may be quite desirable to extend the scope of the exchange to public health and private duty nurses, and also to other than English-speaking countries.

COMMITTEE ON THE USE OF EDUCATIONAL FILMS

As convener of a Committee appointed originally to study "the advisability of recommending the use of motion pictures for teaching purposes in Schools of Nursing" and later appointed to study "cost of producing such pictures," I wish to make the following report:

The Committee has been inactive for these reasons: In the instance of the original objective there was no need for the Committee to function since the value of illustrative material in any form for teaching purposes is indisputable and therefore may be recommended without further study upon the matter. In the instance of the second objective careful consideration has shown that it is quite impossible to form anything approaching a true estimate of the cost involved beyond the following quotations submitted by the Eastman Kodak Company:

Camera (size suitable for making pictures as above)-----	\$180.00
Projector-----	200.00
Film: 1 roll, 100 ft. (including developing and printing)---	8.50
Lamps: 750-watt, 2' hours burning power (2 required at 35 cents)-----	.70
Reflectors (2 required at \$18)-	36.00

(a) Camera, projector, films and lamps are necessary equipment.

(b) Lamps (750-watt) do not require special voltage wires, but may be used in any ordinary building. Any kind of a portable stand with a good reflector may be used for these special high-power lamps.

(c) Films (100-ft.) are good for four minutes at average speed and may be run continuously or intermittently as desired. Extra copies taken from a negative cost \$3.00 per roll of 100 ft.

(d) Camera has two speeds and is easily run by an amateur photographer.

(e) The main parts of the above equipment are manufactured in the U.S.A., sent to Canada under very small duty, and assembled into the finished article in Canadian factories.

Other factors to consider in endeavouring to estimate the cost of producing motion pictures are as follows: whether there is required any extra paid labour; the usage of electricity; the usage of dressings, drugs, etc.; the number of rolls of film required; whether the procedure being filmed is done for teaching purposes only or done of necessity for a patient; etc., etc.

(Sgd.) OLGA V. LILLY, Convener.

COMMITTEE OF COMPARATIVE COSTS OF NATIONAL OFFICE

For some months a special committee of the Canadian Nurses Association has been studying the comparative cost of publishing *The Canadian Nurse* in Western and Eastern centres. This study has involved other matters, such as the advisability of changing the National Office of the Canadian Nurses Association, and the appointment of a part-time or full-time editor for the magazine.

The members of this committee, Misses E. MacP. Dickson, Toronto; Gertrude Garvin, Ottawa; Jean Wilson, Winnipeg; Olga Lilly and M. F. Hersey, Montreal, were not able to arrange meetings, and the work has been carried on by correspondence only.

The following recommendations are submitted:

1. That the National Office be moved to Montreal.

2. That an editor for *The Canadian Nurse* be appointed dating from January 1, 1933. (A decision as to full-time or part-time service to be decided following discussion at Saint John.)

3. That the office of the Executive Secretary of the Canadian Nurses Association and the Editor and Business Manager of *The Canadian Nurse* be adjacent (if possible), and that they be under separate management.

4. That the cost of such an appointment be met by the regular funds of the Association for an experimental period of two years.

Respectfully submitted.

(Sgd.) M. F. HERSEY,
Convener.

COMMITTEE ON INCREASE OF MEMBERSHIP BY 1934

Realising that the Canadian Nurses Association should aim for a great increase in membership by the date of the twenty-fifth anniversary of the Association, which will be celebrated at the General Meeting, 1934, it was decided by the Executive that a committee should be formed to encourage this increase. As the possibility of increase in membership is greatest in

Ontario, it was decided to appoint a member of the Registered Nurses Association of Ontario to be convener.

To date no action has been taken, but it is planned to have on the Committee representatives from each Province, who will stimulate membership in their provincial associations in the way best adapted to their type of organisation. Membership in all the provinces except Ontario and Prince Edward Island is automatic with annual registration. In these two provinces membership in the Provincial Association has no connection with registration, with the result that the membership is much less than the number of nurses registered for the year. For instance, in Ontario about 8,000 nurses register annually and the present membership of the R.N.A.O. is just over 2,100.

The Committee bespeaks the co-operation of each member of the Canadian Nurses Association to assist in every way to encourage this desired increase in membership, which is so truly needed if the Association is to be really representative of the nurses of Canada.

(Sgd.) MARY B. MILLMAN,
Convener.

RESOLUTIONS

From General Sessions

Resolved:

THAT the National Office be moved to Montreal.

THAT an Editor and Business Manager for *The Canadian Nurse* be appointed, the details of her duties to be left to the Executive Committee and that the cost of such an appointment be met by the regular funds of the Association for an experimental period of two years.

THAT the office of the Executive Secretary of the Canadian Nurses Association and the Editor and Business Manager of *The Canadian Nurse* be adjacent (if possible), and that they be under separate management.

THAT the policy of financing the Sections remain as it is, and that the surplus at the end of each two-year period be returned to the general treasury.

THAT the Canadian Nurses Association, in session June 21, 25, 1932, desires to open negotiations with the General Nursing Council of England and Wales for the purpose of making possible reciprocity for registration of trained nurses from Canada.

THAT the President and Miss Jean Gunn (Second Vice-President, I.C.N.), and four unnamed delegates represent the Canadian Nurses Association at the International Council of Nurses Congress, 1933; and that the naming of the delegates be left to the Executive Committee, but that they be representative of the three Sections: that a French-speaking nurse be one of the delegates.

THAT the exchange nurse be given salary by the hospital in which she is serving and that she shall pay her own travelling expenses. Any scholarship given to a nurse shall be considered as outside the business arrangements of the Committee on Exchange of Nurses.

THAT the Exchange of Nurses Committee be requested to develop some scheme whereby the exchange of nurses within the Dominion of Canada may be effected, and to continue their efforts to establish some plan for exchange abroad.

THAT District Association No. 1, R.N.A.O., place itself on record as approving July rather than June for the date of the Canadian Nurses Association General Meetings, as any date after July 1st is more satisfactory to the majority of nurses, particularly public health nurses engaged in school work.

THAT a letter be sent to Dr. G. M. Weir and the University of British Columbia expressing the warm appreciation of the C.N.A. for the signal service rendered in directing the Survey of Nursing Education in Canada.

THAT letters of thanks be sent to the following for their contribution towards the success of the Convention: The Hon. Vincent Massey, P.C., LL.D.; the Rev. C. Gordon Lawrence, the Hon. C. D. Richards, His Worship Mr. Jas. W. Brittain, Mayor of Saint John; Dr. W. W. White, Professor Roy Fraser, Professor F. Clarke, Dr. S. R. D. Hewitt, Dr. G. Stewart Cameron, the Saint John Medical Association, the Press (national and local), Miss Murdoch and the Arrangements Committee; the New Brunswick Department of Health, the New Brunswick Association of Registered Nurses, St. Joseph's Hospital, the Saint John Tuberculosis Hospital, the Saint John General Hospital, the Hotel Management, the Retiring Officers (Miss Ellis and Miss Simpson), the Staff at the National Office.

From Survey Report Sessions

Re the Approved Training School

Resolved:

THAT an approved school must be equipped and staffed to give satisfactory instruction in the five major departments, namely, medicine, surgery, obstetrics, pediatrics and communicable diseases.

THAT an approved school should set junior matriculation or graduation from a special high school course prepared for nurses as its entrance standard.

THAT not later than June 30, 1935, all approved schools should set junior matricula-

tion, or graduation from high school, or graduation from a special high school course prepared for nurses as an entrance standard.

THAT all students in approved schools be at least nineteen years of age.

THAT all students of approved schools shall have a yearly physical examination.

THAT in all approved schools the eight-hour day should obtain, including class hours if possible.

THAT in approved schools, the plan which Dr. Weir outlines for a nursing internship shall be put into effect.

THAT approved schools give preference to the special high school course for nurses when this is established.

THAT steps be taken to bring nursing education into the general educational scheme of the province.

THAT the importance of teaching the principles of health work throughout the entire course and the value of experience in some phase of public health work during the student's training shall be stressed.

THAT the standard should be raised for nurse registration examinations and that these examinations be held in fewer centres.

THAT in order that the experience of the small hospital, which is undoubtedly of value to the nurse in fulfilling her responsibilities to the community after she graduates, may not be lost, it is recommended that a comprehensive plan be formulated whereby such opportunities may be adequately utilized in post-graduate work and through a system of interchange of nurses within the Dominion of Canada.

THAT the Executive Committee of the C.N.A. be requested to present to the members in general session in 1932 the desirability of planning a measure, whereby the Provincial Registered Nurses Associations might confer, through specially selected representatives, on the subject of law amendments, in the hope that all such might provide more uniform demands; and also that provision for national registration be considered before the next General Meeting of the Association in 1934.

Re the Analysis of the Cost of Nursing Education

Resolved:

THAT the C.N.A. communicate with the Boards of Trustees of all Canadian hospitals conducting training schools for nurses, with the following suggestions:

1. That the Board of Trustees study the Survey of Nursing Education in Canada, especially those sections dealing with the education of the student nurse.

2. That each hospital undertake a definite study of nursing costs within its own institution with a view to estimating and comparing the cost of nursing education and nursing service.

THAT the Board of Trustees co-operate in working out a uniform method of cost ac-

counting for use in all hospitals conducting training schools for nurses and in placing the training school for nurses on the budget system.

THAT the Board of Trustees definitely study the curriculum of the training school for nurses in order to estimate the extent to which the programme of nursing education definitely benefits the nursing service in that individual hospital.

THAT after definite knowledge of the actual cost of nursing education and nursing service is available, the Board of Trustees co-operate in an effort to secure governmental subsidy for the net cost of nursing education, which is given in the Survey in the following terms: "The net cost of educating the student nurse is the difference between the total cost of her education and the monetary value to the hospital of her services."

THAT the Board of Trustees be notified of the appointment in each province of the Provincial Study Committee, and their interest and co-operation solicited.

Re the Distribution of Nursing Services Resolved:

THAT hospital boards be circularised by the C.N.A. regarding the desirability for a material reduction in their student nurse personnel, and whatever increase necessary in the staff of graduate nurses.

THAT Provincial Joint Study Committees be asked to make a special study of superannuation schemes for nurses.

THAT the C.N.A. recommend that the Provincial Joint Study Committees be asked by the Provincial Nurses Associations to wait upon the official bodies concerned with compulsory health insurance (in the provinces which already have it under consideration), with a view to impressing upon these bodies the necessity of socialising nursing services, as recommended in the Weir Report.

THAT the National Joint Study Committee be asked by the C.N.A. to study the question of a Dominion Bureau of Nursing as recommended in the Weir Report, and report back to the C.N.A.

THAT the Provincial Associations be asked to instruct the Provincial Joint Study Committees to study the question of petitioning the Provincial Governments to enact compulsory licensing of all who give nursing care to the sick for hire and to report back to the Provincial Associations for action.

From the Nursing Education Section

Resolved:

THAT whereas the number of nurses being graduated annually from the schools of nursing in Canada far exceeds the demand for their services, with resulting serious unemployment and economic distress, the C.N.A. recommends that all hospitals conducting schools of nursing be asked to consider a reduction in the number of students enrolled, and the substitution of graduate nursing service.

THAT the C.N.A. be asked to recommend to the provinces the serious study of the relationship of the size of the hospital to nurse training, and if possible to define specifically the term "adequate clinical material for nurse training," "desirable qualifications of instructors," and "the ratio between the number of instructors and students."

THAT in view of the increasing difficulties created by the more rigid enforcement of the immigration laws of the United States, which has resulted in the non-admission to the United States of students from Canada accepted by the schools of nursing in that country, it is recommended that the Canadian Nurses Association communicate with the American Nurses Association asking that the superintendents of the schools of nursing in the United States be asked to make certain that the students will be allowed to enter the United States before the student is accepted by the school of nursing, thus preventing unnecessary expense, disappointment and serious inconvenience to the student concerned.

From Public Health Section

Resolved:

THAT the C.N.A. be requested to make every effort to include public health nurses in its plans for national and international exchange of nurses.

THAT the C.N.A. be requested to send a resolution to the Minister of the Department of Pensions and Health, requesting that a representative from the C.N.A. be appointed to the Dominion Council of Health.

THAT whereas nursing education is a subject of general and not sectional concern, and requires for its best development the contributions of all branches of nursing, therefore be it resolved that the C.N.A. be requested to consider the formation of a central organisation, apart from and contributed to by the Private Duty, Public Health and Hospital or Institutional Sections, to carry on the study and related activities of nursing education.

THAT the following resolution be forwarded by the C.N.A. to the Programme Committee for the General Meeting, 1934: "That open meetings of the sections be held, similar to those arranged at the annual meetings of the Registered Nurses Association of Ontario."

From Private Duty Section (Recommendations)

THAT the graduate private duty nurse should possess minimum academic qualifications equal to, though not necessarily identical with, junior matriculation.

THAT the present economic status of the average private duty nurse should be considerably improved.

THAT the private duty and other nurses should co-operate with the medical profession, hospital officials, and the laity in giving group and hourly nursing a fair trial.

Reports of Provincial Associations

ALBERTA ASSOCIATION OF REGISTERED NURSES

Objectives: The objectives of the Association of the Alberta Registered Nurses are to protect the members of the Association, and maintain standards in the nursing profession. To foster interest and cohesion among the members and to further the growth of the Association.

Membership: (a) Basis of membership: Provincial R.N. Examinations and approval of Senate of University. (b) Number of members: 563 on April 29th, 1932. (c) All nurses completing their registration in Alberta automatically become members of the Association. (d) Percentage of members subscribing to *The Canadian Nurse*, 5.1%.

Sections Organised: (a) Nursing Education; (b) Private Duty; (c) Public Health.

Standing and Special Committees: In 1931 a Joint Study Committee for consideration of the Weir Survey Report was appointed.

In 1932 a committee was appointed to study the Revision of the Constitution and By-laws of the Registered Nurses Association.

A special committee was appointed to investigate certain recommendations regarding the establishment of recognised Training Schools in Mental Hospitals.

A committee was appointed to confer with the Provincial Red Cross Society regarding the Voluntary Enrolment of Nurses for Emergency service.

Annual Meeting: (a) The date of the last annual meeting was March 22nd and 23rd, 1932, held in Edmonton.

(b) Content of sessions, etc.:

President's address; Secretary-Treasurer's and Registrar's reports. There was an increase in membership of 42 nurses over the membership of 1930. Guest speakers were Miss Jean Browne, Secretary of the National

Joint Study Committee, Toronto; Dr. C. A. Barager, Commissioner of Mental Hospitals for Alberta; and Miss Catherine Lynch, Matron, Provincial Mental Hospital, Ponoka.

The Association was fortunate in having Miss Jean Browne, who gave two very interesting and illuminating addresses on the Survey Report.

Dr. Barager spoke on The Problems and Relationship of Mental Nursing, and Miss C. Lynch on Some Problems in Mental Nursing.

The remainder of the session was occupied in discussing the Survey Report, the National Office, and reports from the various sections.

A delegate was appointed to the C.N.A. Convention at Saint John in June.

(c) Officers elected:

President, Miss F. Munroe; First Vice-President, Mrs. de Satge; Second Vice-President, Miss S. Macdonald; Secretary-Treasurer, Miss K. S. Brighty.

Special Interests: Special interests, activities and accomplishments include:

1. The Senate of the University of Alberta Regulations require that the bed capacity of small hospitals wishing to conduct schools of nursing be increased to 100 beds.

2. An Inspection Committee for Schools of Nursing appointed by the Senate of the University. The personnel of this Committee represents the medical profession, the nursing profession and the laity. Those appointed are: Dr. J. J. Ower, Provincial Pathologist; Miss Eleanor McPhedran, President, A.A.R.N., and member of the Senate of the University; and Professor A. E. Ottewell, Registrar of the University of Alberta.

3. Unemployment among Nurses: Of special interest to the Association is the loan fund sponsored by the Edmonton Graduate Nurses Association. This fund has been subscribed

to by nurses in permanent positions in the province, and is safeguarded by a committee whose duty it is to grant loans to nurses needing financial assistance due to the present economic conditions.

A special scholarship was granted in 1931 to Miss Elizabeth C. Shirley, Calgary General Hospital, 1925, who entered a post-graduate course in Administration at the School for Graduate Nurses, McGill University, Montreal.

Other features or trends which characterise the work of the organisation are:

1. A special committee was appointed in 1931 and is making a study of the Registered Nurses Act, and By-laws of the A.A.R.N., with a view to bringing in recommendations for the revision of the same.

2. Members of the Public Health Section have pledged themselves to do their utmost towards increasing the number of subscribers to *The Canadian Nurse*.

(Sgd.) KATE S. BRIGHTY,
Secretary-Treasurer.

GRADUATE NURSES ASSOCIATION OF BRITISH COLUMBIA

Objectives of the Association: The continued effort to uphold nursing standards in British Columbia.

Membership: (a) Basis of Membership: Graduate of an accredited training school in British Columbia, or a graduate of an accredited school whose qualifications are equal to those demanded of our graduates. The educational standard must be equal to that asked of our graduates also.

(b) The Association has a membership of 2,016.

(c) All registered nurses in the province are members of the Association.

(d) In April, 1932, 102 members were subscribers to *The Canadian Nurse*.

Sections organised are: Nursing Education, Private Duty, and Public Health.

Standing and Special Committees are: Public Health, Private Duty, Nursing Education, Programme, Press, Nominating and Legislative. Special Committees are arranged as occasion requires. Those active at the present time are: Red Cross Emergency Service, Hourly Nursing Service, Survey, Library, Pensions and Insurance for Nurses, Registries.

Annual Meetings: Easter Monday of each year is the date set for the annual meeting of the Association. The content of sessions are similar to those of other nursing organisations. Officers are elected for a two-year period, that is, from April, 1931, to April, 1933.

Special Interest, Activities and Accomplishments: Two scholarships were awarded in 1930 and one in 1931. A refresher course was held in 1932. A committee of nurses studied educational standards together with two principals of Vancouver schools, to evolve the best course for nurses now available in the high school curriculum. An effort was made to obtain a summer course at the University of British Columbia. Owing to conditions existing at the present time the University of British Columbia could not grant this, but will do all possible to help nurses in the field to obtain their certificates by attendance at sessions, not necessarily in one year. Distribution of the questionnaires relative to the Survey of Nursing Education in Canada was undertaken. Consideration has been given to the unemployment of nurses. The interest of the Association has also been directed toward Red Cross Emergency Service and Hourly Nursing Service.

Other features or trends which characterise the work of organisation are routine attention to re-registration of provincial nurses annually, inspection of training schools in British Columbia, control of arrangements and financing of examinations for Registered Nurses' certificates and registration of nurses.

(Sgd.) HELEN RANDAL, Registrar.

NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

The New Brunswick Association of Registered Nurses is organised for the following purposes: To provide a body of well educated, thoroughly trained nurses for the intelligent and sympathetic care of the sick: to promote professional and educational advancement: to elevate the standards of nursing education: to improve the character of nursing service in all fields of nursing endeavour.

The basis of membership is registration in the Province of New Brunswick. To date, 933 R.N. certificates have been issued: this number includes the certificates issued to members now deceased, those who have resigned from active duty, those who have entered other occupational fields. About 75% of the nurses engaged in active duty throughout the province is included in the membership. On January 1st of this year, the number in good standing was 349. A total of 66 names are on the subscribers' list of *The Canadian Nurse*, less than 6% of the total number available.

Three sections are organised, Public Health, Private Duty and Nursing Education. Three standing committees are now functioning: Legislation and By-laws Committee, The Canadian Nurse, and of recent formation, the Joint Study Committee.

The annual meeting is held in the month of September each year. The date, a flexible one, usually occurs in the third week of the month. Decision regarding the date is left to the Executive Council. The meeting occupies two full days for completion. Reports are read from the secretary-treasurer and registrar, the auditor, secretary of the Examining Board, the conveners of the sections and standing committees, the secretaries of the four local Chapters organised in the provincial districts. Discussion is freely participated in concerning the business indicated in the reports by all interested. One or more

outstanding speakers are usually heard on desired topics.

The meeting concludes with the election for one year of the ensuing officers: President, First and Second Vice Presidents, Hon. Secretary, twelve Councillors. The conveners of the three sections and standing committees are elected also. The Association employs one part-time salaried worker, who serves as Secretary-Treasurer, Registrar and Secretary of the Examining Board.

Registration examinations are held twice yearly, on the first Wednesday and Thursday of every May and November. The examinations are under the direct control of a Board of Examiners, whose membership is made up of the following: Three nurses who serve for a period of three years, and two physicians, appointed by the Provincial Council of Surgeons.

The special interest and activity of the past two years has been an effort to incorporate into the Registration Act a compulsory standard of education as a requirement for all prospective students desiring to enter the provincial nursing schools. Satisfactory completion of Grade X was the standard unanimously agreed upon by the Association. A most unfortunate reception was met with from the legislative body, and the amendment to the Act, for the time, was withdrawn.

In the interests of establishing some form of provincial school inspection, correspondence has been carried on with the secretaries of the Associations of Registered Nurses of Nova Scotia and Prince Edward Island. A plan in mind is to create a Maritime Board of Nurses, under this to have a qualified Nurse Inspector or Advisor for the Maritime Schools of Nursing. At the moment, New Brunswick is unable to finance a share in this effort.

One outstanding accomplishment is the growing membership. There are two reasons for this: a registration

fee raised to ten dollars includes a year's membership in the Association, and the list of all members of the Association in good standing for the past year is published in a newspaper of provincial circulation, in addition to that which is published every January in the Royal Gazette. It has come to be more and more a matter of concern not to be left off the publicly printed list of Registered Nurses in good standing.

This year the New Brunswick Association of Registered Nurses has the honour and the pleasure of being hostess to the Canadian Nurses Association at the Biennial Meeting in Saint John. It is the earnest wish of the members of the Provincial Association that their duties as hostesses may be so competently and graciously performed, the welcome to the guests so cordially extended, that we may have, readily granted, their permission to call this latest effort an accomplishment.

(Sgd.) MAUDE E. RETALLICK,
Secretary-Treasurer and Registrar.

THE REGISTERED NURSES ASSOCIATION OF NOVA SCOTIA

Objectives: To provide a special organisation for graduate nurses, and to do all such things as from time to time may be necessary to elevate the status and advance the purposes of the Association;

To unite the members of the profession into one general body; to provide for the better definition and protection of graduate nurses, and the supply of educated and trained members, and the issue of certificates;

To promote and foster among the members of the profession a high sense of the importance of professional training and to protect the mutual interests of the members;

To provide opportunities for intercourse among the members, and to give facilities for the reading of papers, the delivery of lectures and for the acquisition and dissemination by other means of the most approved

methods and scientific teaching of nursing;

To assist necessitous members, and to act as trustees of any benevolent fund or funds which may be contributed for any purpose.

Membership: Basis of membership: Graduation from an approved School of Nursing. Preliminary education of, at least, the equivalent of Grade X (public schools of Nova Scotia).

Number of Members: 580 (of which 346 are fully paid up).

All registered nurses are members of this Association—all registered nurses in Nova Scotia.

Percentage of members subscribing to *The Canadian Nurse*, about 10% of paid-up members.

Sections Organised: Public Health, Private Duty, Nursing Education.

Other Standing Committees: Library, Legislative, Programme and Publications, Red Cross Emergency Corps, Registrar's Advisory, Arrangements, Nominations.

Annual Meeting: Date, June 1st and 2nd, 1932, in Antigonish. Programme: Reports of Officers; Reports of Conveners of Committees; Reports from Branches of Association; Discussions and recommendations arising from above; Discussion regarding Instructors in Schools of Nursing; Discussion of the Office of Inspector of Schools of Nursing; Discussion of Higher Educational Qualifications for Entrance to Schools of Nursing; Discussion of Pooling of Expenses of Delegates to National Association and Members of National Executive Committee; Discussion of Survey of Nursing Education in Canada; Appointment of Delegates to Canadian Nurses Association for Biennial Meeting in Saint John.

Officers Elected: President, Miss A. Slattery; First Vice-President, Miss V. Winslow; Second Vice-President, Miss E. Grant; Third Vice-President, Miss G. MacKenzie; Recording Secretary, Mrs. D. Gillis; Corresponding Secretary, Treasurer and Registrar, Miss L. F. Fraser.

Special Interests: Registry for private duty nurses. Preliminary education of entrants to training schools. The Red Cross Emergency Corps has about 46 volunteers.

All schools of nursing in Nova Scotia have the three years' course of study now, except the Victoria General Hospital School of Nursing for Male Nurses (which is still two and one-half years).

Ninety-four members were admitted in year 1930-1931.

One hundred and seven members were admitted in year 1931-1932 (to date). Five nurses, graduates of the Victoria General Hospital, have had the H. J. Crowe Scholarship and have taken courses at the School for Graduate Nurses at McGill University, Montreal; two are now on the staff of training schools of nursing in Nova Scotia. Miss Margaret E. MacKenzie, President, was appointed a member of the Dominion Board of the Victorian Order of Nurses, at the request of that organisation. Two more industrial nurses have been engaged in the province—one by the Canadian National Railway Company at the terminals in Halifax, and the other by the T. Eaton Company, Maritimes, Ltd., at the stores in Halifax.

Features Characterising the Work of this Organisation: Adoption of the following resolutions:

That a Maternity Hospital graduate admitted to a General Hospital School of Nursing be allowed only three months for that training in the course of general training of the School of Nursing entered by such Maternity Hospital graduate.

That all students in the Schools of Nursing be required to make up any time which exceeds nine weeks. This includes all vacations and leaves of absence during the three years' course of training. Candidates for registration examinations who are pupil nurses shall not be eligible to write same until within six weeks of completion of the prescribed course of his or her hospital.

Affiliation fees for 486 members (paid up to 31st August, 1930) were forwarded to the Canadian Nurses Association for year before last and for 367 members (paid up to 31st December, 1931), for last year.

(Sgd.) L. F. FRASER,
Registrar.

THE MANITOBA ASSOCIATION OF REGISTERED NURSES

Objects: (1) To advance the educational standards of nursing. (2) The standardisation of training schools in Manitoba. (3) To maintain the honour and status of the nursing profession and render service in the interest of the public.

Membership: (1) Graduate nurses who are registered according to the Nurses Act of Manitoba are eligible for membership in the Manitoba Association of Registered Nurses on payment of the initial fee of \$10.00, and an annual renewal fee of \$2.00. (2) There are 2,426 registrants in the province since 1914. (3) The active membership would be about 700. Of these, 370 are paid-up members for 1932, which means that just over 50% only are paid-up members of this Association. (4) About 20% of the paid-up members subscribe to *The Canadian Nurse*.

Sections Organised: 1. Nursing Education Section was organised in 1924. During 1930 this Section compiled a suggested minimum curriculum for schools of nursing in Manitoba, and in 1931 arranged a refresher course for graduate nurses in co-operation with the Provincial Department of Public Health. The members of the Section are hopeful of being able to arrange a Department of Nursing at the University of Manitoba. The Section is at present making a study of the recent report of the Survey of Nursing Education in Canada.

2. The Private Duty Section was organised in 1921, and during the past two years this Section has held many meetings of its members. The

private duty nurses are all desirous of a shorter working day, and the ten-hour day was inaugurated and tried out with more or less success. The present condition of unemployment among the members of this Section is their greatest problem.

3. The Public Health Section was organised in Manitoba in 1919. During 1930-31 this Section sponsored a number of lectures and talks on matters of health interest, which were all well attended.

Standing and Special Committees: The Association is managed by a Board composed of fifteen members, who are in office for a period of two years, and who meet as often as necessary to attend to the affairs of the Association.

1. The Legislative Committee is especially selected by the Board to attend to such matters as amending the by-laws and presenting these to the Provincial Legislature.

2. The Membership Committee endeavours to secure new members and assist in the matter of payment of renewal fees.

3. The Directory Committee is composed of members of the Association representing all branches of nursing, and transact business relating to the Directory.

4. The Sick Visiting Committee visits all members who are ill and report to the next General Meeting.

5. The Social and Programme Committee attends to the social and literary matters which may be necessary for the welfare and professional advancement of the Association.

6. The Nominating Committee is appointed usually two months before the Annual Meeting to nominate new officers for the Board.

7. The Librarian attends to the arrangement of books and magazines of the Association, also to the lending and return of same.

Last year in Manitoba two special committees were appointed: one to look into the matter of unemployment among Private Duty Nurses; the second, the Joint Study Committee.

was formed to study the recent Report of the Survey of Nursing Education in Canada.

The Committee on Unemployment was asked by the Board of the M.A.R.N. to investigate the circumstances of some three hundred private duty nurses who were registered on the list of the Manitoba Nurses' Central Directory, and also to bring back some suggested measures for relief. Following this, early in 1932, a sum of \$3,000 was voted by the M.A.R.N. from the Association funds, this money to pay for work created for the relief of unemployed nurses in the province of Manitoba.

This scheme has been put into operation and has helped in some measure to relieve the situation temporarily. Under the method adopted for distribution of this fund, any patient in hospital who is seriously ill and unable to pay for special nursing care is allotted a nurse for a period up to twenty days, the nurse being paid at the rate of \$3.15 per day, the hospital supplying her meals free of charge. The use of this service has been offered to the organisation doing hourly nursing work should a patient in a home need all-day care. Under this scheme, up to the present, employment has been given to forty registered nurses. The Alumnae Associations of the larger hospitals co-operating with the M.A.R.N. have evolved a scheme to raise money for their unemployed graduates. The members of the Alumnae who are employed give one per cent. of their salary and the married members also contribute. The money is used to pay for group nursing, etc., for patients who need and cannot afford to pay for special nursing care.

The Annual Meeting: The annual meeting of this Association is held in January each year, usually in the third week, but the date may be arranged by the members of the Board. The meetings usually comprise an afternoon and evening session. The afternoon session is devoted to the presenting of annual reports submit-

ted by the following: President, Corresponding Secretary, Recording Secretary, Registrar, Treasurer.

Sections: Private Duty, Nursing Education, Public Health.

Committees: Legislative, Directory, Membership, Sick Visiting, Social and Programme, Librarian.

Representatives: Local Council of Women, Central Council of Social Agencies, Victorian Order of Nurses, Canadian Red Cross.

A dinner meeting is held during the evening, at which time there is a guest speaker, who delivers an address on some current event. Officers are elected at the annual meeting to replace members on the Board whose term of office has expired. Conveners of committees and representatives to other affiliated organisations are also elected at this time.

Over the period from June, 1930, till June, 1932, the Manitoba Association of Registered Nurses has held eighteen meetings of the members of the Board and eight general meetings of the members, the business of the Association being conducted at the Board meetings. The general meeting usually took the form of a dinner gathering of the members, when a speaker of some distinction later addressed the meeting on some subject of current interest. This year the opinion of this Association on certain phases of public health work was asked for by the Pratt Commission on Public Health in the Province of Manitoba. A reply was compiled by the conveners of the three Sections, Private Duty, Public Health, and Nursing Education, and forwarded to the Secretary of this Commission.

This Association is affiliated with the Canadian Nurses Association, Canadian Red Cross, Local Council of Women, Central Council of Social Agencies, and contributes financially to the support of a native nurse in the Punjab, India.

A contribution was made also to the Mary Aikens Memorial Fund, which had as an objective the furnishing of a ward in the Children's Sec-

tion of the Winnipeg General Hospital.

Also, a donation was made to the Women's Service Bureau, an organisation which devotes its efforts to assisting unemployed women and girls of the business world.

The Association owns a set of lantern slides depicting the History of Nursing, and these slides are lent in turn to all of the hospitals, with schools of nursing, in Manitoba.

(Sgd.) S. GORDON KERR,
Secretary-Treasurer.

REGISTERED NURSES ASSOCIATION OF ONTARIO

Objectives: The objectives of the Association are: to advance the educational standards of nursing; to maintain the honour and status of the nursing profession and to render service in the interest of the public.

Membership: (a) Basis of membership, voluntary; (b) number of members, 2,046; (c) 13.4% of the registered nurses in Ontario are members of their Provincial Association; (d) approximately 25% of the members of the Association subscribe to *The Canadian Nurse*.

Sections: Nursing Education Section: Perhaps the most important work undertaken by this section was the Refresher Course for Nurse Instructors and Administrators given by the Extension Department of the University of Toronto, in November, 1930. Seventy full-time and thirty part-time students attended.

An outline of the Undergraduate Course in Mental Hygiene and Psychiatric Nursing at the Toronto Psychiatric Hospital, and for the Post-Graduate Course in Mental Nursing at the Ontario Hospital, Whitby, was given at the annual meeting in 1932. The establishment of these courses shows a marked progress in the field of mental nursing.

Private Duty Section: The private duty nurses in the districts throughout the province are planning to hold study groups to study Dr. Weir's Report of the Survey of Nursing in Canada.

Public Health Section: The Public Health Section of District No. 5 arranged for a Maternal Care Institute in February, 1932. This was conducted by Miss Ethel Cryderman, Ontario Supervisor, Victorian Order of Nurses for Canada, and held in a class room at the Toronto General Hospital. Twenty-two nurses registered for the Institute.

Standing Committees: The Legislation Committee in 1931 revised the Constitution and By-laws of the Association.

Special Committees: 1. The Provincial Joint Committee with the Ontario Division, Canadian Red Cross Society, reports that 298 registered nurses have enrolled for emergency service in war or disaster.

2. The Provincial Joint Study Committee has held one meeting, when recommendations were drawn up to be brought back to the Ontario Medical Association and the Registered Nurses Association of Ontario, with suggestions to increase the personnel to include representatives from other organisations in the province. Study groups have been formed throughout the province.

3. The Permanent Education Fund Committee reports that \$1,147.97 has been contributed by the members of the Association. This fund was established in 1930 by means of levying an annual tax of \$1.00 per member for five years, the purpose in mind being to provide funds to finance the preparation of specially qualified persons for educational administrative work, which will benefit the nursing profession in the province.

4. The Exhibition Committee report that \$350.00 had been realised from the commercial exhibits at the annual meeting in 1931 and approximately \$275.00 in 1932.

5. The reports of the activities of the Council of Nurse Education since 1930 show that Ontario now has a list of approved Schools for Nurses. At the examinations for registration in November, 1932, only candidates from approved schools will be per-

mitted to sit for examination. During the past year, fourteen hospitals of 15-50 bed capacity have discontinued their schools, and their students then in training were placed by the Inspector of Training Schools to complete their training elsewhere.

6. At the annual meeting in 1932 an interim report was presented on a proposed Nursing Matriculation Course as the standard requirement for entrance to schools for nurses in this province. The special committee appointed—by the Ontario Department of Education and consisting of nurse educators and high and vocational school principals—to formulate this course, hopes to obtain its approval by the Senate of the University of Toronto and the Ministers of Education and Health, so that it may be introduced into high and vocational schools next September. Following discussion in the general meeting, the Board of Directors appointed a committee to study and report on this question.

Annual Meeting: The annual meeting was held in Ottawa, March 31st, April 1st-2nd, 1932, with a registration of 338.

The meeting dealt principally with the study of the Report of the Survey of Nursing Education in Canada. At the open sessions summaries of the Report in relation to Nurse Education, Private Duty and Public Health Nursing were presented.

The guest speaker at the banquet was Dr. Stewart Cameron, Chairman, Joint Study Committee, Survey of Nursing Education in Canada. Dr. Cameron's address was based on some of the findings contained in Dr. Weir's Report.

Officers for 1932-33 are: President, Miss Mary B. Millman; First Vice-President, Miss Marjorie Buck; Second Vice-President, Miss Priscilla Campbell; Secretary - Treasurer, Matilda E. Fitzgerald.

(Sgd.) MATILDA E. FITZGERALD,
Secretary-Treasurer.

GRADUATE NURSES ASSOCIATION OF PRINCE EDWARD ISLAND

Objects: The Graduate Nurses Association of Prince Edward Island has for its objectives:

1. To provide a special organisation of graduate nurses so that the members of the profession may be united into one general body: to promote and protect the mutual interests of the members.

2. To do all such things as from time to time may be necessary to elevate and advance the nursing profession in the province and to foster among the members a sense of the importance of a high standard of professional training.

Membership: There are two classes of membership, namely: active and inactive members. Active members are those practising in the province. Inactive members are those residing in the province but who are not practising nursing, and those located elsewhere.

An active member becoming an inactive member notifies the secretary-treasurer of the change; and change in status of dues becomes effective at the annual meeting following receipt of notice. Members in arrears for two consecutive years are notified by the secretary-treasurer, and those members failing to pay within three months after such notice, forfeit the right of membership and their names are taken from the roll of members.

Members who have been dropped for non-payment of dues may be reinstated by paying full registration fee.

Registration Membership: The incorporators under the Registered Nurses Act and every person who

(a) Resides in and practises, or proposes to practise, the profession of nursing in the province, and is a graduate of an approved training school;

(b) Is of good moral character, and

(c) Is at least twenty-one years of age, and

(d) Has passed an examination before the examiners as provided by this Act

shall on producing satisfactory evidence to the council in proof of such qualifications and on complying with all other requirements contained in the Act, be entitled to be registered as a member of the Association.

Persons who are registered as trained nurses in any other province or country which has substantially the same requirements for registration as this province, and whose qualifications are approved by the Board of Examiners, shall be registered without examination on presenting registration certificate of province, country, to registrar.

The names of two hundred and two (202) nurses have been enrolled on the register since the Nurses' Registration Act was passed in May, 1922, only seventy-two (72) of whom remain on the active list and twelve on the inactive list. Of the remaining 118, twelve names are still on the list, being in arrears but one year. The others according to the by-laws have forfeited their right to membership, but may be reinstated upon payment of initial registration fee.

All nurses receiving registration in this province automatically become members of the Graduate Nurses Association of P.E.I. Eight per cent. of members are subscribers to *The Canadian Nurse*.

Sections: Conveners of the Public Health, Private Duty and Nursing Education Sections are elected annually by the Association. The Private Duty Section has been organised and has held several meetings during the year. It consists of the convener and members of the Association actually engaged or interested in private duty nursing. The other two sections have not been organised.

Standing Committees: Programme, Auditing, and Sick-visiting are appointed at the annual meeting.

Annual Meeting: The annual meeting of the Association is held on the second Monday of June at such hour and place as may be decided upon. The following order of business is carried out: Minutes of the last meeting and quarterly meetings held throughout the year; business arising out of the minutes; report of the Secretary and Registrar; report of the Treasurer; reports of Standing and Special Committees; reports of Private Duty Sections, resolutions, etc.; new business; election of officers; programme—addresses, music, etc.; annual dinner.

Officers elected (1931): President, Miss Lillian Pidgeon; Vice-President, Miss Bertha Darrach; Secretary-Treasurer, Miss Anna Mair (re-elected).

Special Activities During Year: Revision of by-laws; tentative minimum curriculum for provincial training schools; addresses: Pre-natal Care, Dr. Tidmarsh; Public Health in P.E.I., Miss McKenna, P.H.N.; History of Nursing, Hon. Dr. W. J. McMillan, Minister of Health and Education; distribution and study of Report of the Survey of Nursing Education in Canada; annual picnic.

(Sgd.) ANNA MAIR,
Secretary-Treasurer.

THE ASSOCIATION OF REGISTERED NURSES OF THE PROVINCE OF QUEBEC

1. *Objectives of the Association:* To provide a body of fully trained and competent nurses for the care of the sick, and to provide means whereby those who possess such competency and training may be made known to the public, and also to promote the efficiency, usefulness and welfare of nurses generally.

2. *Membership:* (a) Basis—In so much that the Board of Management of the A.R.N.P.Q. constitutes the council on Nursing Education in the Province of Quebec and that the registration law places in their hands the administration thereof, all nurses

registered in Quebec automatically become members of the Association.

(b) Number of members:

Members in good standing.....	3,237
French-speaking sisters	286
French-speaking lay sisters.....	874
	—1,160
English-speaking members	1,494
Members on non-active list.....	583
Arrears 1930 and 1931	361
	—3,598

(c) All registered nurses in Quebec Province are members of the A.R.N.P.Q.

(d) It is reported with regret that of the English-speaking members alone (2,094) only 219 or 10.4% subscribe to *The Canadian Nurse*.

3. *Sections Organised:* As the Association is a bi-lingual one, the Nursing Education Sections are organised separately, with a convener and executive committee appointed by each group.

The Public Health Section is organised as one group, carrying out its duties in both languages; the convener is an English-speaking member and her executive committee is composed of both French and English members. The conveners of the sections are members of the Board of Management of the Association, and by their reports keep the Board informed as to the activities of their respective groups.

4. *Standing and Special Committees:* (a) An Advisory Board, composed of English and French-speaking nurses who have rendered conspicuous service to nursing and nursing education in the province, renders to the Board of Management the advice and aid solicited.

(b) A Board of Nurse Examiners, composed of English and French-speaking members, is appointed by the Board of Management; each member serves for a period of three years. This Board controls the registration examinations, which are prepared by them; the French-speaking members also serve on the examining boards of the two French Universities (Montreal and Laval), whose examinations are recognised when the

French nurses who have passed them apply for registration.

(c) The three sections are listed in the by-laws as standing committees.

(d) A Finance Committee of four members, including the honorary treasurer, is appointed by the Board of Management.

(e) A Special Committee for the Study of the Survey Report has been appointed through which numerous study groups have been formed and are functioning.

(f) Special Programme and Nomination Committees are appointed each year prior to the annual meeting. These serve their special purpose until the end of the meeting.

5. *Annual Meeting*: The annual meeting must be held in January and usually lasts two days.

This year it was held on January 25th and 26th, 1932. The afternoon session held on January 25th constituted a general business session, when all reports were delivered in both languages, resolutions presented and adopted, scrutineers appointed, etc.

The evening session, January 25th, was intensely interesting and popular. Unfortunately hundreds were turned away for lack of accommodation. Two outstanding speakers presented most interesting and timely addresses: Dr. J. E. Gendreau, Ph.D., Director of the Provincial Radium Institute, on "La Lutte contre le Cancer" ("The Campaign against Cancer"), the lecturer turning fluently from one language to the other throughout the entire lecture in his inimitable and charming manner. The second paper was delivered by Dr. A. T. Bazin, a member of the Joint Study Committee of the Nursing Survey, who gave a most wonderful abstract of the Survey Report, which was limited to the lateness of the hour, and to be continued at a future date. The future date arrived on April 7th. On the second day, two morning sessions took place, one for the French-speaking members at Hotel-Dieu, the other at The Children's Memorial Hospital, where Drs.

Cushing and Mitchell (Chief Medical Officer and Superintendent respectively) rendered a most interesting lecture and demonstration on Medical and Nursing Care in Poliomyelitis. The demonstration of the respirator (modified Drinkwater) was skilfully given by members of the nursing staff.

The last session of the annual meeting took the form of a pageant arranged by the Public Health Section, under the able direction of Miss Marion E. Nash, convener of the section and Educational Director of the V.O.N. of Greater Montreal District. The pageant, which was conducted in French and English, consisted of demonstrations of the various branches of public health nursing work in the province and was entitled *The Public Health Nurse in Town and Country*. This session, after votes of thanks were extended, resolved itself into a friendly tea party, at which over 400 members were present, the remainder of the 600 who were present at the session being unable to remain.

The Board of Management consists of ten members, five of whom are elected by the nurses at the annual meeting to serve a term of two years. The following officers were elected by the Board, from among their number, to serve during 1932: President, Miss Mabel K. Holt, R.N. (re-elected); Vice-President (English), Miss Caroline Barrett, R.N. (re-elected); Vice-President (French) Mademoiselle Edna Lynch, R.N. Hon. Treasurer, Miss Olga V. Lilly, R.N. (re-elected); Hon. Secretary, Miss Elsie Allder, R.N.; other members—Miss Flora A. George, Miss Marion E. Nash, Madame Caroline Vachen, Miss Sara Matheson, Miss Charlotte Nixon.

6. The special interests and activities of the Association comprise the education of student nurses in the province and their registration after graduation. To achieve this end, the Board appoints the Official School Visitor, who is also the Executive Secretary and Registrar of the As-

sociation, thus providing the required supervision in all the schools in an effort to ascertain whether or not the law requirements are being followed. Facilities for nursing and for methods of teaching are determined before schools are approved.

The accomplishments realised during the past two years through school inspection have been as follows:

1. The closing of a school in a special mental hospital and the introduction of plans therein for the provision of a special course in psychiatry and nursing of mental patients for post-graduate and affiliated nursing students.

2. The preparation and introduction into all schools of a minimum course in pediatrics.

3. A marked increase in the number of affiliations for education and experience in nursing and communicable diseases.

4. A considerable increase in the number of full-time nurse instructors in the schools, most of whom have had special preparation for their work through post-graduate education.

5. A greater understanding of common problems and a decided desire among smaller schools to compete with the larger.

6. The establishment of a larger number of modern teaching units and a more standard form of record keeping.

7. In a desire to assist the members to pursue post-graduate courses, two scholarships of \$250 each are awarded annually, one each to a French and English-speaking member.

In an effort to teach the nurses the value and responsibility of State registration for nurses, a centralised course in Nursing Legislation has been arranged, two groups being presented annually from all the English schools in Montreal and those students which are affiliated with them. The course is conducted by the Registrar, who also gives a fifteen-hour course yearly on the same subject to the students in the School for Graduate Nurses, McGill University.

Five hundred copies of the Report of Survey of Nursing Education in Canada have been disposed of through the Association office, thirty of which were presented with compliments to leaders in education, religion, and health organisations, both French and English, throughout the province.

An additional 100 copies of the report have been received, which there is every reason to believe will be sold.

The Board of Management has ordered the translation and production in the French language of the Abstract of the Survey Report as prepared by Dr. Bazin. It is anticipated a sale of over 1,000 copies of the translation to those French members who are unable to read English will be made.

(Sgd.) E. FRANCES UPTON,
Executive Secretary and Registrar.

SASKATCHEWAN REGISTERED NURSES ASSOCIATION

Objectives: The objectives of the Association are the interests of the nursing profession at large, and to raise the standards of the profession to an equal standing with other professions. This Association has tried to make a study of the Survey this year in an endeavour to understand its recommendations and improve the organisation thereby.

Membership: Registration is conducted in Saskatchewan by examination under a Board of Examiners appointed by the University of Saskatchewan or applications from other provinces or states with standards equal to those of this province are accepted on their own merits. During the past year 386 paid-up members were on record. Since registration went into effect in 1917, over seventeen hundred nurses have registered, but only about twenty-one per cent. are still active members. About twenty per cent. of the members are subscribers to *The Canadian Nurse*.

Sections: (1) Nursing Education; (2) Private Duty; (3) Public Health.

Standing and Special Committees: Standing committees are the three

sections just named. Two special committees have been formed recently: a Scholarship Committee of five members and a Legislative Committee of three members. At the annual meeting in 1931, it was decided to make the scholarship of five hundred dollars an annual award, alternating yearly for Public Health or Hospital Administration. Three scholarships have been awarded since the committee was formed. The scholarship student agrees to return to Saskatchewan for at least two years: the first student, Miss E. Amas, has been Instructor of Nurses for almost two years since her return in the Saskatoon City Hospital. The second student, Miss L. Lynch, is engaged in school work in Regina.

Annual Meeting: The annual meeting is usually held for three days in Easter week. This year it was thought advisable to have a two-day session on account of economic conditions. The two days were spent in studying the Survey Report. Papers were given by eight nurses and a complete resumé of the Survey Report was given by Dr. Quance, Dean of Education, University of Saskatchewan, at an evening meeting.

Officers elected for the coming year were as follows: President, Miss E. Smith; First Vice-President, Miss R. M. Simpson; Second Vice-President, Miss M. H. McGill; Councillors, Miss G. M. Watson and Sister Mary Raphael.

The work of the organisation is carried on by the members of the Council, in three or four Council meetings each year and by special committees, with a general annual meeting. Distances and separation of cities makes it very difficult to get members together for special meetings.

The Association hopes to revise the Registration Act and increase the educational standard for registered nurses through the newly formed Legislative Committee.

Representation has been made to the Minister of Public Health requesting that his attention be given to the matter of only registered nurses being allowed to hold hospital positions in the province and to the discontinuance of training schools for nurses in hospitals having less than seventy-five beds.

(Sgd.) E. E. GRAHAM,
Secretary-Treasurer and Registrar.

Reprints of the following addresses are available at the National Office, Canadian Nurses Association, 511 Boyd Building, Winnipeg, Man.:

1. The Survey and the Public, by the Hon. Vincent Massey—5 cents each.
2. The Medical and Nursing Professions and the Survey Report, by Dr. G. Stewart Cameron.

Life, Profession and School, by Professor F. Clarke.

The Scientist and the Survey Report, by Professor Roy Fraser.

These three addresses (No. 2) are combined in pamphlet form—20c a copy or six pamphlets to one address, \$1.00.

Nightingale Week

By Miss GRACE M. FAIRLEY, Vancouver General Hospital, Vancouver, B.C.

Probably one of the most interesting and unique conferences in the recent history of nursing was that, arranged by the National Council of Nurses of Great Britain on "The Florence Nightingale International Foundation," held at London on the week of July 4th.

Some months previously invitations had been sent to the National Associations. Delegates from ten countries were present.

The Florence Nightingale Committee of the International Council of Nurses had been somewhat inactive for a number of years, although at the 1929 Congress held in Montreal it was reorganised, with Mrs. Bedford Fenwick as Chairman.

That any memorial to Florence Nightingale should be educational in form was a foregone conclusion, and for this reason, when the League of Red Cross Societies announced its decision to discontinue the International School at Bedford College, London, which it had financed for eleven years, it was not surprising that the Committee thought seriously of suggesting that some such course should be the aim of the I.C.N. to perpetuate the memory of a leader such as Florence Nightingale, who was essentially an educationist.

It was to discuss this suggestion or any other proposed scheme that the Conference was arranged, and those delegates privileged to be present were unanimous that nothing had been left undone in the week's programme to create an atmosphere that essentially belonged to her, who had done so much for the nursing profession throughout the length and breadth of the universe.

The small group, representing Belgium, Bulgaria, Canada, Denmark, Finland, Great Britain, Holland, Norway, India and Scotland, with Mrs. Bedford Fenwick, President of the National Council of Nurses of Great Britain, and Founder of the I.C.N.;

Mrs. Maynard Carter, Chief of the Nursing Section, League of Red Cross Societies; and Miss Reimann, Secretary of the I.C.N., met in conference on the proposed "Foundation," at 39 Portland Place, London (Headquarters of the National Council), on the morning of July 4th, 1932. From then until the final session on Friday, July 8th, every moment was taken up with visits to places of interest in or connected with Florence Nightingale.

The opening conference was followed by an exhibition of "Nightingaliana," which has been collected with great foresight by the British Council, under the able guidance of Mrs. Bedford Fenwick and Miss A. M. Bushby. Letters, photographs, prints and many priceless personal belongings, and the original copy of her Treatise on "Sanitation in India, 1872," were among the collection so thoughtfully arranged for this occasion by Miss Bushby and by the courtesy of Miss Lloyd Still, St. Thomas's Hospital.

Probably the most delightful day, so rich in atmosphere, was the visit of homage to the grave of Florence Nightingale, when the nurses from the different countries laid floral tributes on the grave so modestly marked "F.N." It was a perfect afternoon, the sun suddenly shining after a heavy rainstorm, and with a silence that bespoke the greatest reverence from the nurses of the world.

Later, a visit to Embly Park, her early home, a beautiful English estate, with exquisite grounds, and little changed from the days when Florence Nightingale as a young woman held Sunday school classes for the children of the vicinity under its stately old trees. The present owners of Embly, Mr. and Mrs. J. J. Crossfield, were most gracious in showing the delegates all that was most closely associated with the early life of Flor-

ence Nightingale and the Nightingale family.

Manchester House—truly international—was next visited. Here the students taking the nursing course reside during the college term. It is a charming old residence, Adam in architecture and delightfully finished, sufficiently informal to remove any feeling of institutional life. Each bedroom has the name of the country of the student occupying it painted on the door and the interior decorations (donated by the nurse students from these countries) are truly national in character and must be a great joy to the students in residence, all of whom come from parts vastly removed from each other in art and atmosphere.

St. Thomas's Hospital was visited, and there, if anywhere, is one conscious of the presence of the founder of our profession. There, the carriage she constantly used at Scutari; there, her uniform; there, the school she endowed and which for years has so wonderfully demonstrated her aspirations and traditions.

The College of Nursing, the General Nursing Council Headquarters, the British College of Nurses, each with its special contribution to the nursing profession, were all visited and the work of the organisation explained by the respective officials.

St. Bartholomew's Hospital, with its interesting Memorial Library to Miss Isla Stewart, and the Church of St. Bartholomew-the-Great, including the Tomb of Rahere, were included in the programme.

The conference was a timely event, as during that week the certificates were presented to the international students who had just completed the 1931-32 course. The diplomas were presented by Her Grace the Duchess of Atholl, M.P., and Miss Venny Snellman, Inspector of Nursing Education in Finland and President of the "Old Internationals Association," gave an address, which for clarity of thought and progressive in point of view, could not have been excelled.

Fourteen students from eleven different countries were enrolled, six in the Public Health Course and eight in the Course in Administration and Teaching.

The social events had all a bearing on the *raison d'être* of the week's deliberations. A luncheon was given by the National Council of Nurses of Great Britain, a tea by the College of Nurses, dinners by the Association of Hospital Matrons and Royal British Nurses' Association. The annual dinner of The Old Internationals at Cowdry Club and a delightful dinner given in honour of the guests at St. Thomas's Hospital by Sir Arthur Stanley, all gave opportunity of hearing references to the Foundation, and one was ever conscious of the delightful opportunities of knowing more and better one's sisters from other countries.

The realisation of the common professional problems was an added bond to those privileged to represent their countries.

A final conference was held on Friday morning at 39 Portland Place, at which a suggested policy was formulated to present to the I.C.N.

Should the Nightingale Memorial take the form of a post-graduate course, such as is at present being given at Bedford College, it will mean that each country will have to pledge itself to grant at least one scholarship annually—in the proximity of \$1,000, and also to set aside a similar amount towards a permanent endowment fund. It is hoped that the work of the Committee will be ready to present at the 1933 Congress in Paris.

Whatever the sentiment of the different countries may be as to the type of memorial, it is generally conceded that it should be educational in character, truly international in scope, and that it should be put into effect within the next few years. Let us hope that the vision of this great leader of health education will be immortalized by nurses the world over.

Nurses Honoured

MISS E. M. MUSSON

Her friends in Canada were delighted to learn of the honour conferred on Miss E. M. Musson when she received the honorary degree of Doctor of Laws at the University of Leeds. For several years Miss Musson was an Externe Examiner for the Diploma of Nursing of this University. She is Honorary Treasurer of the International Council of Nurses and a graduate with a gold medal of St. Bartholomew's Hospital, London.

As a member of the College of Nursing, she is active in many of the nursing organisations in England and Wales. Formerly a Principal Matron of the Territorial Force Nursing Service, Miss Musson was awarded the Royal Red Cross, and in January, 1928, she was appointed to the rank of Commander of the Order of the British Empire by His Majesty King George.

MISS ELIZABETH SMELLIE

In recognition of the comprehensive programme of maternal welfare carried on by the Victorian Order of Nurses for Canada, the Rockefeller Foundation has extended to Miss Elizabeth Smellie, its Chief Superintendent, an invitation to visit a number of European countries within the next few months to observe and study conditions of maternal welfare there.

In the communication received recently from the Rockefeller Foundation, it was made clear that its interest in the work of the Victorian Order had been intensified by a study of the Survey of the Order's activities made last year by Dr. A. Grant Fleming, Professor of Public Health and Preventive Medicine at McGill University, and that Dr. Fleming's appraisal of the Order and his plea for extension of its service to every Canadian mother in need of it had made a deep impression on the authorities in charge of the awarding of Rockefeller scholarships.

Miss Smellie, who has been Chief Superintendent of the Victorian Order since 1924, had a distinguished record overseas, serving as a nursing sister and matron, and later as assistant to the matron-in-chief in Canada. She was mentioned in despatches and received the Royal Red Cross, first class.



MISS ELIZABETH SMELLIE

Miss Smellie expects to sail from New York early in September, and among other countries will visit England, Denmark, Austria, Germany and Italy, returning to Canada about the middle of December.

Denmark Nurses Bereaved

As the *Journal* goes to press, a message from Headquarters, International Council of Nurses, announces the deaths of Mrs. Henry Tscherning and Miss Charlotte Munck, of Denmark. Mrs. Tscherning, an Honorary President of the I.C.N., was President of the International Organisation from 1918 to 1922.

Miss Munck, who died on July 27th after a brief illness, was President of the Danish Council of Nurses and

Matron of the Bispebjærg Hospital, Copenhagen.

The announcement of the deaths of these two nurses of outstanding ability is a great sorrow to the nurses of Denmark and to their many friends in other countries.

The sincerest sympathy of the Canadian Nurses Association is offered to the members of the Danish Council of Nurses in the loss of these two leaders in nursing.

Notes on Nightingale Week

During "Nightingale Week" each official delegate was presented with a parcel attractively tied with the national colours. Inside the parcel was a card inscribed, "National Council of Nurses of Great Britain, Nightingale Week. This brick from No. 10 South Street, London: the home of Miss Florence Nightingale, O.M., from 1865-1910, was presented to....., July 4th, 1932."

Miss Grace Fairley, who represented the Canadian Nurses Association at Nightingale Week, very kindly brought the brick presented to her to the National Office, where it will be treasured among the archives. For

the Canadian Nurses Association, Miss Fairley placed on the grave of Miss Nightingale a large sheaf of red and white carnations and a small Union Jack, tied with the national colours.

At a meeting of the Executive Committee, Canadian Nurses Association, held in Saint John, N.B., on Saturday, June 26th, 1932, Miss Grace Fairley was appointed Convener of the Florence Nightingale Memorial Committee. C.N.A. The President, Miss Emory, and Miss M. F. Gray are members of the committee. The Convener has power to add other members at her discretion.

How came it, that at so timely a moment a great leader broke in upon the scene? Whence came the visions with science still in the offing that have so swiftly and soundly built the foundations for the function of this vanguard of an emerging womanhood? Questions that neither science nor philosophy can answer. Answered or unanswered, the ever-deepening, ever-expanding stream of life pursues its course.

Leaders have come and gone in swift succession as have their followers, each building better than she knew, each thought lost in the vast spaces of oblivion immortal through the race; their accomplishments a sacred trust and a challenge to bring to greater perfection that body-mind we designate as man; each nurse a potential living force capable of increasing beauty and promotive growth; each the perpetuation of a burning zeal to prove ultimate good.

News Notes

BRITISH COLUMBIA

During the present economic crisis which has caused serious unemployment among nurses in British Columbia, as elsewhere, a number of plans put into effect to relieve the situation are:

Wherever possible, graduate nurses are added to hospital nursing staff. The private pavilion of one hospital is staffed with graduates only; in another the class of probationers was not admitted in January, as customary, this necessitates employment of graduate nurses.

Two nurses' associations have established loan funds from which loans without interest are made. Other associations provide funds by which nurses are given work as far as possible in rotation for a certain number of days. Committees are appointed to administer these funds. One association has instituted the "Mite Box", into which members are asked to deposit a cent a day. This plan has been very successful. In several hospitals nurses are taking extra leave of absence in order to allow others to be employed.

ONTARIO

DISTRICT 6

Chapter 3 of District 6, R.N.A.O., monthly meeting was held at St. Joseph's Hospital, June 28th, at 8 p.m. Owing to the absence of Miss Dixon, president, Miss Anderson acted as chairman. A letter from Miss Mitchell regarding hourly nursing was discussed, also the suggestion that the Survey Report be studied at Chapter meetings as much as possible. A copy of a letter received from Dr. T. G. Routly, General Secretary of the Ontario Medical Association, in connection with the nurse's responsibility in accepting orders from other than regularly qualified practitioners, with regard to the administration of drugs. Another matter for discussion was the fees of the private nurse, which will be brought up at the next district meeting. The event of the meeting was a paper on the Survey Report by Sister Gonzaga, who spoke on "Socialisation of Nursing Service". The speaker, referred to some essentials of a Socialised Nursing Service.

The next meeting is to be held the last Tuesday in September at 8 p.m.

EDITOR'S NOTE:—Owing to limited space it is necessary to hold over until next issue News Notes relating to appointments and social activities.

Sister de Sales, St. Michael's Hospital, Toronto, Called from the Scene of Her Labours

The nursing profession in general, and the graduates of St. Michael's School of Nursing in particular, has sustained a great loss in the death of Sister de Sales, one of the pioneers of St. Michael's Hospital.

In the early morning of June 19th, 1932, at an advanced age, this remarkable life came to a close in the presence of the Superior of the hospital, Sister Margaret, the beloved niece of Sister de Sales. A brief illness from pneumonia, and this devoted sister and efficient nurse, who for forty years had ministered to the sick in this same hospital, peacefully passed away to go to meet her Master, whom she has so faithfully served for such a long period of years.

In 1892, when St. Michael's Hospital and Training School for Nurses

was opened, Sister de Sales, after spending some time at Hotel Dieu in Montreal, returned to Toronto to the staff of St. Michael's Hospital. She became supervisor of third floor of the original building and continued as a supervisor up to a few weeks before her death. To the thirty-eight graduating classes of St. Michael's she has been known and loved as a supervisor, and in the early years of the hospital assisted in teaching practical nursing work. She was an exact and exacting nurse and supervisor, and as one who ever kept before her nurses those words of the late Sir William Osler, "Never forget that the patient is the centre of the scene." Her death comes to the graduates as the passing of a well-loved friend and an outstanding nurse, who watched over their advent into the wider fields of nursing in the world outside of their Alma Mater.

Sister de Sales was not outstanding for doing things of which the world heard much, but for the little things in the every-day life and the long years of continued and generous service, which were indelibly impressed on the lives of those who were so fortunate as to have lived and

worked with her. She possessed the charm and the wit of the Irish race to which she belonged, and her keen sense of humour, mingled with most accurate observation and a beautiful piety, were characteristics of this gentle nurse and sister.

ELIZABETH REGAN.

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are to take place on the 19th and 20th of October, 1932. Requests for application forms should be made at once and form returned before September 19th, together with registration fee of \$10.00, and, if granted, diploma of school. No undergraduates may write unless they have passed successfully all final Training School examinations and are within six weeks of completion of period of training of their school.

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10 Eastern Trust Building, Halifax, N.S.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

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**GRADUATE NURSES ASSOCIATION,
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Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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Meeting, first Monday each month.

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

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A Critical Period

By FLORENCE H. M. EMORY, President, Canadian Nurses Association

A return of the fall season marks a new period of professional activity. True it is that to recall the Saint John meeting and action taken there is inspiring, but that in itself serves only to emphasize the need for carrying to fruition the projects considered during those sessions. The challenge of 1932-34 presses upon us. For the Canadian Nurses Association that period promises to be a critical one.

Two years ago the National Association accepted three objectives around which its activities should centre. The vital need for increased membership was conceded. Through the unanimous support of provincial associations an increase in membership of 9% can be recorded. The organisation has held this matter to be of such urgent import as to have appointed a membership campaign committee to work through the nine provincial associations to ensure a larger membership. With the commemoration of the 25th anniversary of the founding of the Association in 1934, membership must exceed 10,000.

A second interest, and a lively one, has been to facilitate the successful completion of the Survey of Nursing Education. Nor has interest in that project abated. Resolutions passed in Saint John support recommendations of the Report and reflect the urgent need of the early appointment of virile, active provincial joint study committees. The National Association in adopting these resolutions set its seal of approval upon them. We cannot forget certain recommendations not adopted at Saint John: ones regarding which action has been delayed. These should be considered with a view to decision at the biennial

meeting in 1934. The final effectiveness of the Survey rests with provincial action through joint study committees appointed for that express purpose. Florence Nightingale held strongly and quite aptly that "a report is not self-executive." The application is palpable.

A third objective has culminated in the appointment of a full-time Editor and Business Manager for the official organ of the Association: *The Canadian Nurse*. The beginning of November, national headquarters will have moved to Montreal, and the first of the new year will witness the coming of the new Editor. With that appointment the staff of the National Office will be well equipped to care for the interests of the profession: the Executive Secretary functioning in the development of professional matters through closer contact with groups within and without, and the Editor interpreting nursing ideas and ideals, national and international, through the pages of *The Canadian Nurse*. It is inevitable that increased staff brings with it increased financial responsibility. I plead for greater support of the magazine through additional subscriptions. A comparison of these in 1930 and 1931 shows a decrease of 11.3%, with a present subscription list of 1,995. The enforced contrast of a membership of 9,385, with subscriptions totalling 1,995, is not creditable. Nor can the fault be laid at the door of any one affiliated unit. The nine are alike culpable. Through effort extraordinary the last three months of the year can reflect improvement, so that the new Editor may assume her duties with more than an even chance of success.

Let me summarise, briefly, the objects upon which the activities of affiliated units should focus:

1. To co-operate with the national membership campaign committee in an effort for increased membership. With the commemoration of the 25th anniversary of the founding of the Association in June, 1934, membership must exceed 10,000.

2. To appoint representative and strong provincial joint study committees, which will manifest a genius for prudent action. The ultimate value of the Survey is largely in their keeping.

3. To endeavour to increase subscriptions to *The Canadian Nurse*. The Editor and Business Manager should commence an experimental period of two years with reasonable hope of success.

I repeat, a critical period is upon us: a period that affords opportunity for added laurels. With the collective conscience of the profession duly sensitive, with a unified spirit and with hard work, the emergence of success is assured. Echoing the words of the Canadian Premier in his address at the opening of the recent Imperial Conference, we pledge both heart and hand for "what way lie faith and hope, that way we follow."

Canadian Nurses Association

Announcement was made in previous issues of the *Journal* that by unanimous decision at the recent General Meeting of the Canadian Nurses Association, the official representatives of the nine provincial units voted in favour of the National Office operating in Montreal in future.

A lease has been obtained for a suitable suite of offices, and after November 1st, 1932, National Headquarters will function at 401 Crescent Building, St. Catherine and Crescent Streets, Montreal, Que.

The Appointment of an Editor

It is with peculiar satisfaction that the Executive of the Canadian Nurses Association announces the appointment of Miss Ethel Johns as Editor of the official organ of the Association: *The Canadian Nurse*. With the new year the Editor and Business Manager will be at her desk at National Headquarters in Montreal.

Born in England and educated in North Wales, Miss Johns is a graduate of the School for Nurses of the Winnipeg General Hospital. After undertaking a year of study in the Department of Nursing Education at Teachers College, Columbia, University, she held administrative posts in the McKellar General Hospital, Fort William, and in the Children's Hospital, Winnipeg. A third Canadian appointment was the dual position of Director of Nursing of the Vancouver General Hospital and Assistant Professor of the Department of Nursing and Health of the University of British Columbia. While in Winnipeg, manifest interest in communal welfare led Miss Johns to serve as a valued member of the Public Welfare Commission of the Manitoba Government.

But Canada failed to hold her. Four years Miss Johns spent in Europe as Field Director of the Rockefeller Foundation, rendering conspicuous service in the development of nursing in Roumania and Hungary. Immediately upon her return from Europe in 1929 she was appointed Director of Studies of the Committee on Nursing Organisation of the New York Hospital-Cornell Medical College Association. The activities of this committee included not only the formulation of policies for the reorganisation of the School of Nursing, but also the close and active supervision of the planning and

equipment of a residence and school for nurses, which is one of the finest on the continent.

Upon the conclusion of this task Miss Johns was offered and still holds the position of Nurse Associate to the Committee on the Grading of Nursing Schools in the United States of America. In this capacity she has had an exceptional opportunity of familiarising herself with present economic and educational trends in American nursing; an experience which will prove valuable to her in her future work.

This brief biographical sketch would be quite incomplete without reference to Miss Johns' sustained interest in the growth of the profession in Canada throughout the years. This was given tangible proof, while still among us, in her contribution to the Canadian Nurses Association as Secretary of the organisation prior to the appointment of an Executive Secretary.

Miss Johns returns. She brings with her unusual personal gifts and a wealth of experience gained on two continents and in England. She has been absent sufficiently long to have acquired a detachment of outlook and yet to have preserved a depth of insight concerning Canadian nurses and nursing. That constitutes a rare equipment for her task. In the fulfillment of an object for which the Association has worked sedulously, we give to Miss Johns the warmth and loyalty of a united profession. The experiment will continue for two years, and we dare to believe that the ability of the Editor and the response of the nursing group will so synchronize that that period will be prolonged.

FLORENCE H. M. EMORY.

The Approved School for Nurses

Introduced by E. KATHLEEN RUSSELL, Director, Department of Public Health Nursing, University of Toronto, and Nurse Member of the Joint Study Committee, Survey of Nursing Education in Canada.

It may not be very reassuring for me to start the first paper of this morning's session with a trite remark about the "making of history" at this meeting of the Canadian Nurses Association. There seems to have been so much of this making of history and so many makers; apparently it takes a lot of doing! However, the oft-repeated remark must serve again. We may indeed make history, professionally, at this meeting in Saint John, if we will. It is in our own hands to decide. And may heaven help us—though we shan't deserve it—if we fail to rise to this opportunity; for in this case it would seem as if we were beyond the aid of man.

A really momentous thing has happened in the fact that this Survey has been made and the Report published. It is unfortunate that our capacity for wonder seldom seems to be equal to the occasion when really wonderful things happen. But, whether we realise it or not, this startling thing has happened: and the consequences are upon us. The halcyon days of drifting are over. We may rebel against the new suggestions and ignore them, question their use or appropriateness, argue and attempt to deny them. All of this may be done and, doubtless, will be done in more or less abundant measure by each and every one of us. Nevertheless, I am convinced that a certain line has been crossed and that a sufficiently strong effect has been created all over the country so that we can never go back, in professional affairs, to 1931 and its state of being and thinking. What we are going to do with the Survey Report remains yet to be decided, but it is what it has done already with us that I am emphasizing: it has jolted us out of the old rut and a return to exactly the same position will never again be pos-

sible. That is not saying that we cannot get ourselves into a worse position if we insist upon doing so!

Appreciation for Dr. Weir, the maker of the Survey and the author of this Report, is surely in order, and I am glad to add one more word of acknowledgment of our gratitude for the amazingly good piece of work that he has done. Also, I would voice a very sincere feeling of appreciation for the co-operation of the Canadian Medical Association. When we get the necessary detachment for viewing these happenings clearly, we realise that we owe the Canadian Medical Association a great debt of gratitude for the way in which it has worked through this project with us. The debt that we owe the three medical members of the Joint Committee is one that probably we yet fail to realise fully. I do not like superlatives nor care for fulsome praise, but would that I could acknowledge adequately what has been done and the generous professional loyalty of the manner in which it has been done. And in addition, we know that the medical members of the committee have had a support from their own organisation, without which their work could not have been accomplished. If it had not been for the generous and loyal co-operation of the members of the Canadian Medical Association a survey of this kind could not have been made. And here I am speaking of something more valuable than financial help, although the latter also was forthcoming and is most gratefully acknowledged. Finally, I would emphasize the work of our National Association in having carried this project through to completion. A feeling of accomplishment should be brought home to us, not for the purpose of idle boasting, but rather that it may secure to us a quiet strength and courage for the next and even

more difficult phase of work that lies ahead, viz., the action that should follow the Survey Report.

Now we have the Report in front of us, what are we going to do with it? No doubt wise action will be taken, but not too easily. And this because there are certain obstacles lying in our path. We shall probably fare better if we recognise the nature of the obstacles and are prepared to meet them. I note at least three.

First, the natural conservatism that most of us, as adult human beings, display. The *status quo*—if acceptable at all—has all the appeal of convenience and accustomedness and, very often, of sentimental attachment. Suggestions of radical change seldom have much appeal; in fact, are frequently resented. This is not a matter for argument, but it is a general tendency in human behaviour that we do well to recognise.

Secondly, the conflict of loyalties—fit subject for one of the foremost dramatists of our day, and a matter requiring much thought and understanding. There are what might be called the local loyalties claiming their share of attention; and facing these—and apparently in opposition—the larger loyalties whose claim is also undeniable. For instance, there is the small school crying out for support from one who knows of good things that have been done there; there is the smaller province that has ranked low in order in some Survey findings and yet has a hurt feeling that it has contributed indirectly to the higher ranking somewhere else; there is the professional pride that is wounded at some weak point which has been disclosed and feels that all true professional members should fly to its defence. Over against these local interests there is the general claim of nursing, the good of the whole, which is most certainly our responsibility. In our discussions we must think and speak as Canadian nurses, attacking all problems from this general aspect instead of serving as defenders of our local faiths. In the

long run it is only thus that our local needs will be truly served.

Third, there are the material difficulties, e.g., such things as lack of money, lack of personnel and so on. We may have all the will in the world and yet accomplishment may seem an impossibility because of the lack of these things.

All these difficulties must be faced in the discussions of the coming days, but, being ready for them, perhaps they will seem less formidable.

We come now to the special subject of this morning's session, which is a consideration of the Approved School for Nurses. Turning to the Report, we find that this subject appears and re-appears continuously throughout the whole book: and inevitably so, for after all the Survey was a study of nursing education, so that the argument can never get far away from the nursing school. The chapters more directly concerned are 2, 3, 4, 6, 8, 9, 12, 13, 17, 22, 23 and 25. And a number of others might easily be included in this list. From all of this, it has been difficult to choose the small amount that could be discussed with some degree of thoroughness in one morning.

Dr. Weir gives the key to his own attitude in Chapter 2 (page 33), when he describes what he calls the three main schools of nursing thought: (a) the reactionaries, (b) the moderates, and (c) the progressives. Having described them, he proceeds to say:

"The stabilising factor is probably to be found in group (b), representing the moderate group of educational opinion. The adherents of this group, roughly fifty per cent. of the nursing and medical personnel who expressed their views to the Survey, cannot be easily stamped by extreme viewpoints from either quarter."

Here is a note of moderation and calm judgment that gives confidence. At the same time there is a quiet determination to know the facts of the situation and to face these honestly.

Probably one of the greatest services that the author renders in the whole Report is the fact that he emphasizes so insistently the existence of the nursing school. He says "we are now thinking primarily of the education of the student nurse . . . the training school should, first and foremost, be considered an educational institution." (p. 532). And so on, from chapter to chapter, we find this same emphasis, the same determined facing of the fact of a school and what is necessarily involved in such an institution. He presents the three essential constituents of the school, viz., the teacher, the pupil and the curriculum and gives a detailed and critical study of each. In discussing these three, his summary of the situation is that far too often we have a teacher unable to teach, a pupil unable to accept the offered teaching and a curriculum unsuited to its purpose with clinical material insufficient for teaching purposes. This is not to say that Dr. Weir does not ever find good things in nursing schools: on the contrary, again and again and again he expresses appreciation of good work, and special appreciation because he knows that this good work is being done under very great difficulties. But, in making the Survey, he was asked to find out the general condition of our schools and to describe this. Thus we get the summary of the situation as he sees it. And, as I have already said, it is far too often that the school is found wanting and that pupil, teacher and curriculum, all three, show marked shortcomings.

In starting this discussion it will probably help somewhat if we recognize quite frankly that we have, in nursing education, a subject that is inherently complex: for this reason confusion will creep into our discussions with the greatest ease. It is possible that no other professional school has a problem with such peculiar and delicate complications. For instance, teacher training has seemed a difficult and complicated

matter for many very clever administrators, but how small seem the difficulties of arranging practice teaching for a normal school pupil when they are compared with the difficulties of arranging nursing practice for a pupil nurse whose practice material involves always matters of life and death and when her practice deals with work that has to go on with unbroken continuity for twenty-four hours a day and 365 days a year. Never will the matter be simple, but this very fact lays all the greater stress upon the need for clear thinking. It is very hard to keep to this straight and narrow path of clear thought and there are many danger points where we can easily get off into tangled bypaths.

The first danger to clear argument is, as Dr. Weir indicates and as we all know, the almost universal tendency to confuse the nursing school and the nursing service of a hospital. Inevitably the two overlap, and one is involved in the other, but nevertheless they are two quite distinct entities, and no clear argument can be presented unless we accord to each its own identity.

Again there is the tendency (strongly marked with us and our critics) to argue from single isolated cases; that is, to draw a general conclusion from a very small amount of particular evidence. Every one of us could point, doubtless, to one good nurse who has appeared from the poorest possible training conditions (Florence Nightingale!) and also to one very poor nurse who has appeared from exceedingly good conditions. But what do these cases prove? Nothing whatever except that the one person is very good material and the other very poor. There will always be exceptional people, unusually good and unusually poor, but our schools and their procedures cannot be planned in terms of these exceptions.

A third danger point is very common and working fearful mischief in education today. This is the tendency to feel that the value of educational

procedure will be in proportion to its quantity and complexity. It is part of the habit of thought expressed in the "bigger and better" phrase—a curious commentary upon either the weakness of our philosophy or the inadequacy of our speech. Let us hope it is the latter.

There is one more danger point of which I would speak and this at greater length. It is the tendency to argue from the analogy between nursing education and medical education. Just now I have consulted my dictionary and I find the word analogy explained as "agreement in certain respects" and "similarity without identity." Undoubtedly there is similarity and agreement in certain respects between the work of nursing schools and that of medical schools, but the differences might easily take longer to describe than the similarities, including as they do such very important matters as the type of pupil, the character of the occupation for which training is being given, the length of the course, the expectation of professional life, the size of the group being trained, the number of schools and so on. Yet much apparently weighty argument is offered with total disregard to these differences. We need to look carefully at the schools of other professional groups, and in doing so we may find a closer analogy between nursing and some of these others than between nursing and medicine.

Probably a particular illustration will serve best for further discussion of this matter. Medicine seems to have decided that training for a public health officer's work shall be a speciality that is to be added on, by means of post-graduate work, for the medical man who has already qualified as a general practitioner. Likewise all other specialising in medicine is prepared for by means of post-graduate study. Engineering, on the other hand, apparently has looked over its field, has found that its work lies in a number of associated but yet distinct branches and is asking its

undergraduates to select and train for one or another of these, e.g., mining engineering, or chemical engineering or electrical engineering. Again, the teaching profession has seen a similar diversity of work and asks its student in training to select one field, e.g., elementary school work or secondary school work, and to prepare in terms of the selected branch. It remains for us to give some careful thought to nursing to see which, if any, of these procedures should serve as a pattern for our schools. In this connection certain questions must be faced. Is the hospital training in nursing a training for general practice (as the undergraduate's course in medicine) or is it in itself a highly specialised bit of training? Is the routine work of public health nursing an occupation which can be looked upon as a further specialising in hospital or private duty nursing? Or is it just one of several branches of nursing, each of which calls for its own particular content in undergraduate training?

I should like to venture a brief answer to these questions if I may be permitted a long look into the future. I think it highly probable that training for hospital nursing and training for public health nursing may separate, or rather that they will go through a stage of comparative separation, and that they will later re-assemble in the training school, but along a new line of organisation. It will be during the transition period, when the needs of each branch are receiving honest attention, that we may well hope to find the basic training of the general practitioner in nursing, one that would serve well all branches of nursing, and one to which further specialisation could be added by each at will. But the claim that we have that general practitioner's training now in the usual hospital school of nursing is one that I should not care to plead. I should lay the burden of proving the case upon those who make the claim. Let us beware, then, of arguments based upon

comparisons between nursing schools and medical schools.

From all of this it would seem that our task with regard to the nursing school outlines itself very distinctly. The Director of the Survey says that two things must be done

1. To define clearly the task of these nursing schools.

2. To find a way to work straightforwardly at this task in lieu of the circuitous and haphazard routes of the present.

To these I would add a third requirement, namely: to cease from following after false gods in the educational world.

The recommendations that we have chosen for special consideration are quoted in full on the sheets that have been distributed and will be read in connection with the papers that deal with them. The arrangement of topics you will see on the programmes. It is as follows:

1. The Superintendent of Nurses.
2. The Instructors, Nursing and Medical.
3. The Entrance Requirements.

4. The Head Nurse.

5. Hospital Facilities for Teaching.

6. The Curriculum.

7. Registration Acts.

In approaching the discussion I have one special plea to make. If I understand aright the very able man who has written the Report, the last thing in the world that he would want is that the Canadian Nurses Association should just acquiesce in a wholesale fashion in his findings and let all thinking stop there. A tremendous piece of work has been done for us, some of this because the Survey Director has expert ability outside of our field. Now our task consists in picking up the work at this stage. In the light of our special experience we may need to vary the recommendations. But Dr. Weir would be the first person to expect this. The highest compliment we can pay the writer is that, with all fairness and intelligence, we now proceed to "question and perhaps accept"; in other words, to give thought to the recommendations that so richly merit the best that we have to give.

The Superintendent of Nurses and the Instructors, Nursing and Medical

By MABEL K. HOLT, Superintendent, School for Nurses, The Montreal General Hospital, Montreal, Que.

The paper that I have to present to you this morning deals with the qualifications of the Superintendent of Nurses and her assistant the Instructor.

Dr. Weir stresses six qualifications that he considers to be the minimum requirements. I have chosen to speak of two: 1, Personal Qualifications; 2, Executive Experiences.

1. Personal Qualifications: I am deliberately passing over the educational requirements because it is so obvious that one who is chosen to be the lady principal of a training school should have, first of all, that background of knowledge and culture, without which she could hardly main-

tain the dignity of her position or receive the respect due to her from her associates and pupils.

I think it is helpful to familiarise oneself with the lives of those whose callings are similar to one's own, and for myself I have received the greatest inspiration from the biographies of men such as Arnold of Rugby; and women such as Dorothea Beale of Cheltenham; to note that feeling of responsibility for each individual under their care, for the forming of character as well as the giving of instruction. How much time and thought and care do we give to the weak members of our family? Is it not our first impulse to say, "She will

never make a nurse," and dismiss her and our responsibility at the same moment? Dr. Weir tells us that in his judgment it is impossible to say whether a student has the making of a good nurse until possibly the end of the first year. May I quote here from Chapter IX?

"It is ordinarily assumed that the probationary period of three or four months provides reasonable opportunity for the training school staff to estimate the probable fitness of recruits, and to decide what percentage, if any, should be rejected. It is doubtful, however, whether this assumption is a tenable one. The emotional training of the prospective nurse is probably as important as her intellectual or practical education, and it is scarcely reasonable to assume that the peculiarities of the student's personality will be adequately revealed during the brief and rather intensive probationary period."

In discussing principles of education with head mistresses of girls' schools, it always impresses me the amount of time and care bestowed upon the backward students, and those who find it hard to adjust themselves to their surroundings. Surely we should do well to follow more carefully the policy they pursue, and to realise more fully that "it is a far better thing and far more worth all effort to make the unpromising faithful than to make the promising successful."

And how are we going to achieve this? Certainly not by ourselves alone, but by the influence we exert through our staff. "If you want a thing done, do not do it yourself, should be the motto of a ruler for everyday use. Act through others, and educate them thereby to independence, and reserve your strength for things that none but a head can do." How hard it is to apply this maxim to ourselves; the feeling that our fingers should be in every pie is a great temptation to the average superintendent of nurses.

Teaching, then, should be our great opportunity; first with our staff, in regular conferences where the policy of the training school can be discussed and propounded; ideas and criticisms gladly received; and second, with the student body, as teacher of nursing history and ethics, and in meeting their representatives as members of the student council, a feeling of friendly co-operation for the good of all can be established.

2. Executive Experience: I will quote the recommendation in full: "Executive experience for at least one year—such as is obtainable in the capacity of assistant superintendent, or as supervisor of a large hospital ward." I would add here experience also as instructor of nurses.

Page 105: "Institutional positions should, in the judgment of the Survey, be considered among the choicest that the nursing profession can offer. Only high-grade, well-educated nurses should be accepted for these posts. The institutional nurse should enter the training school with matriculation standing or its equivalent. In the approved training school of the future, she will probably spend three years of intensive training, which would ordinarily be quite as exacting and educationally sound as that imparted to undergraduates in Arts. If she should spend an additional year in post-graduate study at an approved school for nurses, she would have obtained a status roughly corresponding to that of the high school teacher with the rank of specialist."

Though this paragraph that I have quoted refers to the institutional nurse, I think the recommendations could well be applied to the superintendent of nurses, who is also principal of the training school, and, as such, the head mistress, as it were. To have had the experience of an instructor of nurses is to possess an intelligent understanding and workable knowledge of the training school curriculum, with which one should sympathetically understand the pro-

blem of teaching the student nurse and at the same time nursing the patients; not fully grasped, I think, by those who have not had this responsibility with its attendant problems.

And secondly, and by no means less important, is the apprenticeship as assistant superintendent of nurses in a well organised and properly controlled training school, where methods of control and supervision, the health and social activities of the student body, careful and precise record keeping can be seen and studied.

As Dr. Weir says, "it is scarcely fair to the superintendent of nurses to demand of her both high-grade excellence in supervision and nursing practice, and specialised training in hospital cost-accounting as well. Her duties as superintendent and principal of the training school are sufficiently important and exacting to engage the whole and unremitting effort of the highest type of womanhood."

Therefore, I think our energies should be bent in organising and planning a system of education for student nurses that will keep them abreast of the times, and yet will manifest a degree of common sense that will assure a thorough training in the best sense of the term, rather than an effort to demonstrate how many hours a training school curriculum can contain.

Qualifications for the Instructors: I think almost all I said regarding the principal of the training school could be equally applied to the instructor. Here again is the necessity for the educational background previous to the professional training, and afterwards the post-graduate study at a university.

The most important staff position is that of the instructor. The student nurse comes more directly under her influence than any other. It is, then, in the choice of a teacher for

one's nurses that we should make our most careful selection. With this in view, might we not select such a one while still in training, watch her development, her influence on others, her attitude towards the work as a whole; the preference being given, if possible, to one with teaching experience?

Most valuable to the prospective instructor is the time spent as ward supervisor before commencing her post-graduate work at a university to prepare her for her special work. The ward supervisor is *ipso facto* a teacher—and, as such, she should be chosen for her position. I do not feel there could be that sympathy between instructors and ward supervisors which is so essential in correlating class room teaching with ward work, unless the former has had experience in the different problems of ward administration. The wards should be considered as the practice field of the student, so that what is taught may immediately be put into practice. "To learn in the doing," therefore, the instructors should spare as much time as possible for follow-up work in the hospital. If it is the custom for probationer nurses to serve the wards in the mornings before class work commences, I think the instructor should be there giving adequate supervision at an hour when routine administration falls most heavily on the ward supervisor. It is inconceivable that any woman can do justice to her work unless she has adequate assistance and complete freedom from other duties.

May I, at the risk of boring you with personal experience, relate what routine we follow in the Montreal General Hospital? In a school of 175 students and seven or eight affiliates, we have three full-time instructors. No other duties are required of them apart from teaching, and supervising lecture and study periods, except occasional relief for an hour or so in the Training School Office. Every Saturday and Sunday are completely

free from duty, and two months each summer allowed for vacation—one only, however, on salary.

I feel in arranging this schedule that we approach more nearly the life of the average school teacher. By this means it is made possible for the instructors to have individual conferences with the students, when the difficult paths may be made smooth and problems unravelled which would otherwise be impossible with the group as a whole. This also applies to the superintendent of nurses, who should, I think, make it easy for the individual to approach her whenever the need is felt.

Before bringing my paper to a close, may I touch for a moment on the problem of providing medical instruction? Dr. Weir advises very strongly the employment of paid medical instructors. In discussing lectures given by the staff doctors he says: "Very few medical instructors, after the initial preparation of their lectures, spend more than twenty minutes in review of the subject matter before facing their classes." And again, "The difficulty, however, lies not so much in knowledge of content as in organisation and adaptation of subject matter to meet the needs of the student nurse." In other words, it is not sufficient for the nurses' needs to give them re-hashed lectures arranged for medical students, but the subject taught should be definitely related to nursing principles, with time allowed for questions and discussions.

Dr. Weir admits that a high-minded doctor will put as much time into the preparation of a lecture he gives gratis as for one he is paid for, but he has personally attended lectures which show a lack of preparation of subject matter and apparently a complete indifference to, or lack of appreciation of, the intellectual needs and capacities of individual members of the class.

It is the opinion of the Survey Report that "if certain medical in-

structors were paid at least ten dollars for each class period, they would probably feel more conscience-bound to give greater value to the student nurses than is sometimes the case under present conditions."

One sees the advisability of employing a regular staff of medical instructors, with consequent centralising of lectures, in order that the cost may be distributed among as many schools as possible, but for the sake of argument I would like to emphasize that when the group is large it is somewhat difficult to handle and always the personal touch is lost. Besides which, there is the added fatigue of going out of the building with a possible change of clothes; the rush and energy this necessitates militating against a receptive mind and studious attitude; especially if there is to be a return to a busy ward and all the neglected work caught up, as it were.

It has been my experience to find the medical staff most ready and willing to assist in the education of the student nurse; in fact, rather seeking for it as a favour than otherwise. No difficulty should be experienced in arranging for these lecture periods if the schedule is drawn up in good time—by this I mean before separating for the summer vacation.

It is our custom to communicate sometime in June with each doctor who is to lecture between September and Christmas, submitting an outline of his previous lectures, asking for changes, if any, and submitting date for his approval. I may say they are again notified two weeks previous to their first lecture. If for some reason the lecture has to be scratched at the last moment, then the instructor seizes this opportunity to conduct a quiz on previous lectures.

In conclusion, I would like to add that I have with me a detailed outline of our doctors' lectures, with corresponding dates, and would be most happy to show them to anyone who is interested.

The Entrance Requirements

By SISTER IGNATIUS, Superintendent, School for Nurses, St. Martha's Hospital,
Antigonish, N.S.

The trend in modern nursing is towards higher education. As in all worthwhile movements, it is essential that a good basis be laid before an attempt is made to improve upon the great structure built through the centuries which represents the nursing profession. The task assigned to me should (if it is going to fulfill its purpose) point out how this can be accomplished to the best possible advantage, for we must admit that without the necessary *entrance requirements* the student who enters the school for nurses today is going to be considerably handicapped in the future, and the public will be denied what is rightly expected of her, because she is not capable of giving the most efficient service.

In constructing this firm basis, the major part of the work has been accomplished by Dr. Weir in his recommendations, which are embodied in the publication of his extensive and intensive Survey—a work for which all nurses are deeply indebted. In reference to entrance requirements, Dr. Weir recommends:

(1) "The minimum academic requirement for admission to approved nursing schools throughout Canada should be junior matriculation or its equivalent. The establishment of a matriculation for nurses is recommended." (From Chapter IX.)

(2) "Until the recommendation immediately above is put into effect the minimum academic requirements for admission to schools for nurses should be the satisfactory completion of three years of the high school course, or its equivalent, as attested by the official records of the proper educational authorities." (From Chapter IX.)

(3) "Not later than June 30, 1935, junior matriculation, or its equivalent, should be required as the minimum standard of admission to schools for nurses. High school graduation (the successful completion of a four-year high school course) should, in those provinces where the latter

course is provided, be accepted as preferable to matriculation." (From Chapter X.)

(4) "Until the immediately above recommendation is effective, all candidates with less than four years' high school education, officially attested, should be given a standardised intelligence test. Candidates with I.Q.'s under a hundred should be rejected." (Chapter X.)

Considering Dr. Weir's experience in the field and the fact that these recommendations are based upon his survey, it is evident that the future progress of the nursing profession will depend to a great extent upon following these as closely as possible. I would venture to suggest that the "equivalent" of junior matriculation be clearly and definitely defined.

Like all progressive movements, the raising of academic entrance requirements will possibly meet with unfavourable comment. There are some who consider the nurse "over-educated" and who claim that her education impedes the quality of her nursing. Is this really true? Or is it the result of a spirit of conservatism which still clings to our people and which does not give them the right perspective? In either case, the only permanent cure for such a fallacy rests upon those in whose hands lies the destiny of educating the student nurse. They must prove to the world that a better educated young lady will make a better practical nurse. To this end, the main purpose of raising our educational standards cannot be too strongly or too frequently stressed; namely, the patient's welfare and the public health welfare at large. If we lose sight of this, our efforts towards higher education are ineffective and the profession of nursing will prove a colossal failure. After all is said and done, it is the practical nurse who is efficient and conscientious that counts. Service is the watchword of

the age. As in all other professions and business ventures, a good education is a splendid basis for a successful nurse.

A few vital questions may help to throw light on this subject. Does an education impede the usefulness or success of a business man? a doctor? a lawyer? a teacher? or any other? The answers to the above questions are certainly all in the negative. Is it logical, then, to assume that the work of the nurse should be impeded by education or made more perfect by the lack of it? We do not think so.

We must remember, however, that there are other requirements in addition to those which are purely academic, and they are highly important. In our laudable desire to elevate the standards of nurse education and to modernise our schools, we must not discount in the least the value of character, personality, aptitude for the work of the nurse, fitness for the profession, home training, neatness and good health. If any one of these is notably lacking in the applicant, she will never make a good nurse. "No amount of theory will compensate for a poorly prepared practical worker," says a noted educator.

If there are and have been failures in the nursing profession, may it not be because one or other of the entrance requirements mentioned here is lacking, rather than that the nurse is "over-educated," as they term it? At least a great many sins charged to the nurse's account might be eliminated if more attention were paid to these essential features of her person-

al *make-up* before her admission. No effort should be spared in doing so, and there should be no hesitancy in culling from our schools today those who are not desirable. It is the efficient nurse that is in demand. If the patient suffers because of any lack of attention it will offer him little comfort to know that the nurse is highly educated. Service alone counts.

Another entrance requirement that is worthy of attention is an age limit set for the applicant. The average twentieth century girl in her 'teens lacks a seriousness of purpose which does not fit her for the responsibilities of a nurse, and the best of them could afford to wait until at least they have completed their twentieth year.

To sum up, then, the entrance requirements, I would suggest: First, that the applicant's intellectual fibre be duly tested and that Dr. Weir's recommendations as to academic work be followed as closely as possible; second, that the applicant should possess the true womanly qualities that are essential in a practical nurse; third, that she be of a type who will radiate health in the sick room or wherever her services are required; fourth, that she has completed her twentieth year; and last, but not least, that she be possessed of sound judgment and common sense.

In conclusion, I wish to congratulate the Canadian Medical Association, the Canadian Nurses Association, Dr. Weir and all who co-operated with him in the great work accomplished in the recent Survey.

The Head Nurse; Hospital Facilities for Teaching; the Curriculum

By GEORGINA L. ROWAN, Superintendent, Grace Hospital, Toronto, Ont.

The Head Nurse

Pages 116-117; Recommendations 1, 2, 3, 5, 7, 8, 10

In considering these recommendations it seems necessary to analyse the duties and responsibilities of the head nurse. Her importance in the hospital scheme cannot be over-estimated. She holds one of the key positions. She interprets to her patients the purpose and spirit of the hospital. They are directly under her supervision; she knows each patient in the unit; his ailments, both mental and physical, and his needs. She learns of his financial worries, of his family and social relationships and their bearing on his illness and hope of recovery. In short, her knowledge, next to that of the family physician, should be of the greatest value in the treatment of the individual patient.

1. Her first care, then, is the welfare of each patient in her unit: she is responsible for seeing that he receives the best possible care.

2. She has next a definite duty towards each nurse under her, especially each student nurse. She must outline the daily care of each patient, and the daily work of each nurse. She and the instructor of nurses should work together, to secure for the student nurses the proper teaching of every available item of clinical value occurring in the ward or unit.

She is expected to judge the quality of each student's work and give a written report of it.

3. She should retain all those duties that bring her in close contact with the doctors. She should, when possible, see daily every doctor who visits her unit.

4. She is responsible for the records of the patients. As these records are permanent and may be later used for various purposes (as legal research, etc.), over a long period of time, this is an important piece of work. She must spend some time in supervising those who perform it, if she does not actually do part of the work herself.

5. The head nurse is responsible for the ordering and distribution of the various supplies used and for the general care of her equipment. On her depends to a large degree the economic functioning of her unit.

6. Often the head nurse has some responsibility for the house-keeping of her own department, co-operating with the housekeeper and the dietitian.

From this analysis it is clear that the head nurse has only a limited time to devote to teaching nurses. But because of her wealth of knowledge of the individual patients and their diseases, what she has to contribute is of the utmost value, because it cannot be secured from any other person. She is the one who can best teach the student the nursing of "the patient as a whole," that much-desired and much-needed lesson.

The importance of recommendation No. 2 is apparent, especially as it is hoped that in future all student nurses will have similar educational standing before entrance.

Regarding No. 3, the experience gained in some branch outside the hospital field will enable the head nurse to understand the future needs of the students whom she is teaching.

In selecting women for these positions, there is need to choose nurses competent to teach some branch of

their profession, as well as to efficiently administer their departments.

Recommendations 7 and 8 need scarcely be enlarged upon here, except to stress the need for additional post-graduate courses in Canada, especially as fewer opportunities are offered in the hospitals of the United States than formerly.

Referring to recommendation 10, the majority of the institutional nurses replying to Dr. Weir's questions felt that more, and better taught, theory should be added to the nursing course. They believed that such an improvement would have increased their own efficiency.

Referring to recommendation 8, the institutional nurses agreed (page 105) on the need for more study and recreation in their work. "They, with their nerve-racking responsibilities, need more time for enjoyment, and contact with the world that is not sick." But often at night, the nurse is too utterly weary to engage in study, and there is great danger of becoming narrow.

The Director considers that it is not humanly possible, according to the best medical and nursing evidence, to give continuously the highest quality of service unless the eight-hour day is adopted for institutional nurses.

To go back to recommendation No. 1, the question of salary is, of course, one of economics. But many of the outstanding nurses in the institutional field today consider the position of head nurse the most desirable of all, probably because it allows them to deal directly with the patient.

Hospital Facilities for Teaching

Page 299; Recommendations 1, 2, 3, 4.

Recommendation 1: Throughout the whole volume, Dr. Weir reiterates this recommendation. Few improvements can be universally adopted

until this minimum is established, and to conduct a school which can offer a well-balanced course, as outlined in recommendation 3, with sufficient staff for teaching, and affiliation to cover the special departments lacking in a small hospital, is a highly expensive procedure. If hospital boards could be informed and persuaded regarding the needs of the present-day nursing course they would, in many cases, realise that the expense involved is greater than the cost of staffing the institution with graduate nurses and adequate domestic helpers.

By closing these smallest schools, a reduction of 13 per cent. in the number of nurses graduated annually would be made.

The Curriculum

Pages 377-8; Recommendations 1, 2, 4, 5, 12.

In introducing the subject of the curriculum, the Director of the Survey points out that one of the major aims of education is the modification of the individual's conduct. Unless education leads to the "emergence of appropriate conduct in life's situations" it can be only partially effective.

He stresses (page 353) the importance of

- (1) the selection of student personnel;
- (2) the quality of instruction—good teachers and methods necessary;
- (3) adequate facilities and teaching equipment.

He further points out that any curriculum is only a means to an end and must be subject to a process of continuous adjustment to meet constantly changing conditions—such as new scientific discoveries and the development of new social needs.

The Director states clearly that a standard curriculum cannot be pre-

pared which will be of general value until

- (1) the schools connected with hospitals of less than 75 beds (exclusive of bassinets), and a daily average of 50, be refused approval;
- (2) some educational standard of entrance be adopted, such as matriculation.

Recommendation 1: This needs little comment. The time is all too short now to cover the ground, including the specialties. Then, too, a certain number of the young women who may pass the earlier tests are found wanting when they reach more advanced work and are unable to take responsibility. More incompetent nurses would be graduated if the course were shortened.

Recommendation 2 has been referred to above.

Recommendation 4: The Director condemns the practice of crowding into the preliminary course, lectures that properly belong to the time when the nurse is having ward experience in that particular subject. Would it not be possible to introduce into the probationary months a course in English? Much criticism has been quoted throughout the Report regarding the lack of knowledge of English grammar and spelling. What other institutions, called by the name of schools, neglect to teach this most important subject?

The Director suggests a course on Elementary Rural and Urban Sociology, centering about the family unit. This could very well be given in the early months. In many schools instruction in public health nursing is not given until the third year, when the student is more able to give and therefore receive benefit from the experience, but some early instruction by a teacher of public health would assist the young student to better understand the patients on the ward.

Recommendation 5: (a) Probably few members of the Canadian Nurses

Association will dispute this section. Dr. Weir's suggestion (page 447) of having paid full-time medical instructors, young doctors with pedagogical training and teaching experience, who would teach as well as lecture, should be considered as a future possibility. Too large classes (as 100) should be avoided.

(b) There is no doubt that since the advent of the highly specialised dietitian, nurses have evaded responsibility in this branch, and the young graduate leaves the school with a very superficial knowledge of, and not much interest in, the preparation and planning of diets. English nurses have spoken of this tendency in the schools of Canada and the United States. Therefore it would seem that a determined effort must be made to regain the old-time interest in foods. Certainly, when nurses go into homes or into the public health field there is need for knowledge and skill in preparing diets, and the ability to give the necessary instruction to the public.

(c) In some provinces courses have already been arranged in Mental Hygiene. There is need for development of such teaching.

Paragraphs (d), (e), (f) are fully discussed in this chapter.

On page 369, Dr. Weir refers to the system of transferring the students from one ward to another of the same type. Such aimless migrating should be avoided. The student should have time to observe the patients throughout their hospital stay, and learn something of the end results.

On page 272, the necessity is stressed of developing among all the graduate staff nurses a sense of their personal responsibility for the success of the training school. Only in this manner can an effective institutional *esprit de corps* be developed: and without this spirit, resembling the so-called college spirit, the success of the school can never be really complete.

The Approved School for Nurses

Resolutions adopted by the Canadian Nurses Association in General Meeting, 1932, following discussion of recommendations submitted after presentation of papers dealing with The Approved School for Nurses, The Report of the Survey of Nursing Education in Canada:

1. The Canadian Nurses Association goes on record as approving and taking such action as is possible to ensure that:

(a) An approved school must be equipped and staffed to give satisfactory instruction in the five major departments; namely, Medicine, Surgery, Obstetrics, Pædiatrics and Communicable Diseases;

(b) An approved school should immediately set junior matriculation, or graduation from a special high school course prepared for nurses, as its entrance standard;

(c) Not later than June 30th, 1935, all approved schools should set junior matriculation, or graduation from high school, or graduation from a special high school course prepared for nurses, as the entrance standard;

(d) All students in approved schools be at least 19 years of age;

(e) All students in approved schools shall have a yearly physical examination;

(f) In all approved schools the eight-hour day should obtain, including class hours if possible;

(g) In approved schools, the plan which Dr. Weir outlines for a nursing

internship shall be put into effect;

(h) Approved schools give preference to the special high school course for nurses when this is established.

2. Steps be taken to bring nursing education into the general educational scheme of the province.

3. The standard should be raised for nurse registration examinations and that these examinations be held in fewer centres.

4. The importance of teaching the principles of health work throughout the entire course and the value of experience in some phase of public health work during the student's training shall be stressed.

5. In order the experience in the small hospital, which is undoubtedly of value to the nurse in fulfilling her responsibilities to the community after she graduates, may not be lost, it is recommended that a comprehensive plan be formulated whereby such opportunities may be adequately utilised in post-graduate work and through a system of interchange of nurses within the Dominion of Canada.

6. The Executive Committee of the Canadian Nurses Association be requested to present to the members in general session in Saint John, 1932, the desirability of planning a measure whereby the Provincial Registered Nurses' Associations might confer through specially selected representatives on the subject of Law Amendments, in the hope that all such might provide for more uniform demands; and also that provision for national registration be considered before the next general meeting of the Association in 1934.

MATERNITY INSTITUTE

At the General Meeting, Canadian Nurses Association, 1932, an announcement regarding the Maternity Institute, conducted by the National Office of the Victorian Order of Nurses for Canada, was made by the Central Supervisor, Miss Ethel Cryderman.

It was explained that the object of the Institute is to afford an opportunity for groups of nurses, including representatives from all branches of nursing, to study under leadership the present maternal welfare situation and to consider how to improve the character and the quality of their services as nurses in this particular field.

The Institute extends over a period of two days, and consists of a series

of lectures, round table conferences, exhibits, demonstrations and general discussions. In two of the sessions representatives from the medical profession participate, and one session is devoted to the nutrition of pregnancy.

Institutes can be sponsored by nursing organisations, local or provincial health departments, or can be arranged for by university extension departments. They can be given in any part of Canada, provided there is a registration of at least fifteen nurses. Where the enrolment exceeds forty, two institutes will be given. The registration fee is three dollars, and the group requesting an institute is responsible for local arrangements.

The International Council of Nurses

A preliminary outline of the programme for the Congress, International Council of Nurses, July 10th to 15th, 1933, announces that the Board of Directors will meet July 4th to 6th, and the Grand Council, July 7th and 8th.

Sessions of the Congress are scheduled to be held in Paris, July 10th to 12th, and in Brussels, July 14th and 15th; Thursday, July 13th, will be spent in travelling from Paris

to Brussels, with interesting sight-seeing and visits on the way.

The President of the Council is Mlle. Chaptal, President of the National Association of Trained Nurses of France.

Many professional subjects are included in the programme, and a large number of nurses are expected to take part in the discussions. Topics chosen for general sessions are:

- International Co-operation and the Nurse.
- The Health Organisation of the League of Nations.
- Inspection of Schools of Nursing by Nurses.
- The Influence of Medical Research on Nursing Service.

The outline for Section Meetings includes:

- Aptitude Tests and Admission Standards to Schools of Nursing.
- The Preliminary Course.
- The Basic Course of Training.
- Supply and Demand.
- State Supervision of Nursing.
- The Legal Aspects of Professional Conduct.
- Private Duty Nursing:

- (1) Hourly Nursing;
 - (2) Schemes for Supervision and Regular Allowances for Private Duty Nurses.

- Public Health Nursing and Social Work.

- Mental Nursing and Hygiene.

- Industrial Nursing.

- School Nursing.

- Hospital Nursing.

- Rural Nursing.

- Nursing in Colonies.

- New Developments in Nursing.

- Summary of the Findings in Recent Nursing Surveys.

- Insurance Schemes for Nurses.

- Nurses as Secretarial Officers and Professional Journalists.

- How to Stimulate the Interest of the Public in Nursing.

Nursing Technique in Communicable Diseases and Nursing Procedures will be demonstrated on three occasions.

The reception of newly affiliated national associations is an attractive and colourful ceremony. Mrs. Bedford Fenwick, Founder of the International Council of Nurses and President of the National Council of Nurses of Great Britain, will preside at the reception session.

To be admitted to take part in the Congress a Canadian nurse must be approved by the Canadian Nurses Association; that is, she must be a member in good standing in one of the nine provincial associations of registered nurses.

The Canadian Nurses Association has placed all arrangements for transportation of its members to the Congress with Thos. Cook & Son.

While steamship rates have never been so low as now, it is impossible to predict that they will remain the same for any length of time. The present rates from Montreal or Quebec to Cherbourg, returning from a British port to Quebec or Montreal, are:

First Class	\$296.00
Cabin Class	231.00
Tourist Class	165.00
Third Class	123.00

A special Canadian party will sail from a Canadian port. However, individual members who may find it

necessary to sail at an earlier date will be accorded that privilege.

The present low steamship fares, reduced travel rates in Europe and also reduced cost of hotel accommodation provide excellent opportunity for nurses to attend the Congress.

At present there is in preparation several special itineraries, which will include the period of the Congress as well as other interesting European cities, particularly those that appeal to nurses. These itineraries and other information as available will be published in the next issue of the *Journal*.

VISCOUNT KNUTSFORD

"In Black and White"

To be resourceful is a great asset for a nurse, and I remember one—I have lost sight of her now—who ought to have gone far on that account. She has, however, never nursed me! A group of our nurses were up for their "Pass" and "Honours" examination and, as usual, two beds were provided, each with its "patient," a small convalescent boy from one of the wards, for the purposes of practical demonstration, bandaging, splint fitting, and so on. The examiner went up to one bed and told the candidate that she was to imagine that the patient had

had an accident and had been brought in with a fractured base—what would she do? She was nervous and could not collect her thoughts, so the examiner, very kindly, wishing to give her every chance, left her and went off to the other bed to start another candidate. He came back to find the patient stiff and still, eyes closed and the hands folded decorously across the breast.

"Good heavens! Fractured bases don't all die."

"This one did," replied the candidate firmly.

THE CANADIAN NURSE

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Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, Nurses' Residence, Winnipeg General Hospital, Winnipeg, Man.

CHAIRMAN'S ADDRESS

By GRACE M. FAIRLEY, Vancouver, B.C.

To the members of the Nursing Education Section:

I think you will agree with me that when we adjourned two years ago we had little idea how full our future programme was going to be. As in these two short sessions we have a great deal of business to cover and plans to lay for the guidance of both incoming executive and individual members, my remarks are going to be very brief.

The Secretary's report will cover the activities of the past two years, and it is for you who are present to give the greatest help you can in laying the foundation of our future policy and teaching programme. You can best do this by contributing to the discussion and expressing your views freely.

Our responsibilities to the profession are great—so great that to some of we older members it would seem that we are not likely to see all our plans fulfilled, but if we do nothing more than give our sincerest thought and advice and keep our minds unbiased, I have no fear that the results will not be sound.

Therefore I ask for your co-operation during these sessions and your pledge to help by individual effort until you are satisfied that our system of education is satisfactory.

The next two years will be very important ones in the history of our profession, and the Nursing Education Sections, both provincial and national, must of necessity be very active; but the individual members

must take their share. Our problems are common ones, and it is in the solution of these common problems that our duty lies.

THE GENERAL DUTY NURSE

An excerpt from discussion on The Curriculum in Canadian Schools of Nursing and Readjustment in the Education Programme:

"... There is one group in the hospital field that has grown very rapidly since our last meeting, and one which I feel requires to be included in our teaching programme, and if time will permit I should like to consider what we can do to develop that ever-growing body of General Duty Nurses. They do not, as far as I know, enter into staff conferences, and yet is it not from this group that we hope to see the head nurse of the future develop?

Some of you may have worked out some plan; if so, I hope you will tell us of it. Probably you have read Miss Effie Taylor's most interesting article on "Good Nursing Service Defined and Explained," in which she says "the hospital is the training centre in which present and future nurses receive their education. In order to maintain a good nursing service every nurse *must* continue to be a student." It is my belief in that theory and in the need of our hospitals offering study facilities for every nurse that urges me to make a plea for the young general duty nurse.

I hope, therefore, you will give all the help you can in the nature of free discussion of the curriculum and the changes that are necessary to make the graduate of the future ready to meet responsibilities.

GRACE M. FAIRLEY.

A Discussion of the Survey Report from the Educational Angle

By Miss MARION LINDEBURGH, Assistant to the Director, School for Graduate Nurses, McGill University, Montreal.

The whole problem of nursing education in the undergraduate school can be discussed under two main headings, administration and teaching. In that the programme of this convention has already provided so adequately for the discussion of many aspects relating to these two major functions, and particularly of administrative nature, this paper will be more strictly confined to a discussion of educational requirements of a professional nursing school, as formulated in the Survey Report.

The concept of an "Approved Nursing School" has received due consideration on the programme. In terms of logical sequence this topic was assigned the rightful place, as the initial consideration of the requirements of a professional nursing school. The starting point in the possible solution of the problem of nursing education is in the set-up of an institution with adequate clinical and teaching facilities, through which the education of the student can be made possible. This consideration is of such initial importance that in its practical application it demands an analysis of every school in Canada, and there is no possible question as to the advisability of adopting a procedure for the discontinuance of existing schools which cannot measure up to a set and recognised standard. This can only be accomplished by a rigid and intelligent method of inspection. Dr. Weir suggests that the person provincially appointed to undertake this analysis should not only have an understanding of the principles of administration, but should have an appreciation of the fundamentals of education, as applied to the requirements of a professional nursing school.

While we recognise the very valuable and necessary function of the small hospital in the small or scattered community, it does not follow that every hospital is justified in conducting a nursing school. Setting an educational standard for the establishment of nursing schools will be of immeasurable value in correcting our present serious situation—in decreasing the number of nursing schools and candidates admitted each year, thus allowing for the assimilation of graduates into the smaller hospitals, and in improving the quality of professional nursing service, the function for which we exist.

A school of nursing should primarily exist for the education of the student nurse and not to supply nursing service for the hospital. In this statement we are not minimising nor losing sight of the objective for which the graduate nurse exists; namely, the efficient care of her patient, or professional service in the community. But the student must first be educated, and it is obvious that under the present system her education is sacrificed in meeting the demand of student nursing service within the hospital institution. Dr. Weir criticises severely the policy of nursing education in return for student nursing service. He predicts that the professional nursing school of the future will be an institution whose educational standards will be provincially approved, and that they will be maintained on the same basis as are the provincial normal schools. The public *must* be educated to their responsibility in the education of nurses, just as they have recognised for some time their responsibility in the education of teachers.

Under such control the criterion for determining the annual quota of students entering schools of nursing will be in terms of the need for graduate

service in the community rather than to meet the demands of hospitals for student nursing service, which has resulted in the present critical situation of over-production. We have only to note the nature of the control which is being exercised in the teaching profession to realise how haphazard and dangerous is our present system. Some systematic method of curtailment of nursing school candidates should be immediately adopted.

The second consideration which follows in logical order is: who shall enter this "approved training school?" The question of entrance requirements—of intelligence, health and personality—has been carefully considered. One cannot pass over this important issue, however, without endorsing the statement that schools of nursing can never receive full professional recognition until there is a recognised educational level for the admission of students. There must be a recognised academic basis upon which to build the professional curriculum. The teaching profession is many years ahead of us in its attempt to define definite levels of qualification. A student entering a normal school with full high school standing receives, upon graduation, a *first class* professional diploma and in their professional service in the schools they are rated accordingly.

In contrast we realise we have a long way to go in this respect. At the present time an "R.N." carries with it little professional significance. As shown by statistical figures in the Report, it means anything from a grade VI, with training in an inadequate school, to junior matriculation or university credits and training in a school offering ample facilities for professional education. This heterogeneous mass is permitted to enter the graduate nursing field, in many cases not because of adequate education, but through the "open sieve" character of the R.N. examinations. Unfortunately for us, the public estimates the status of the nursing

profession by the type and qualifications of individual members with whom it comes in contact, and the sum total of such judgments cannot be placed on the credit side of our account.

A third consideration in the set-up of a professional school is provision for an adequate educational programme. This implies "curriculum construction," and this essential has been most purposefully discussed in its many aspects. The concept of the term "curriculum" in modern educational theory suggests much more than just subjects to be taught. It includes all activities which contribute to the personal, social and professional development of the individual. A professional curriculum must be broad in its concept, recognising the student not only as a potential professional worker, but as an individual member of society who should be privileged to develop her own particular personal and social interests. The oversight of this objective is one of our traditional defects. Until recently a nurse was supposed to be a nurse in spirit and in service, twenty-four hours of the day, but such an attitude cannot be accepted in this modern democratic age. As cited in the Lancet Commission Report, this attitude is the chief reason why nursing is distasteful to the modern, educated girl, and it constitutes one of the chief difficulties in securing suitable candidates in many of the nursing schools in England today. If nursing is to compete successfully with other professions, it must provide for personal and social liberty.

In the provision for adequate content of any professional curriculum there are many well recognised and modern theories to be considered. Every profession should be considered not only as an *art* but as a *science*. In the evolutionary development of nursing education, during apprenticeship, stress was laid on the skill aspect, with little or no consid-

eration for the provision of scientific knowledge through which practice could be made intelligent. Gradually, through the institution of the classroom and the introduction of scientific knowledge, nursing was raised from the level of technical training to the lower levels of education. Florence Nightingale clearly saw nursing as an education rather than a training, and still farther, she saw the nurse as a health educator—a concept which today constitutes one of our modern curriculum objectives, but which has as yet only been partially realised. Since Florence Nightingale's time, nursing schools have been struggling, in the face of hospital obligations, to improve the scope and quality of the knowledge content of their curricula. The large proportion of practice, in relation to theory, which still characterises nursing school curricula is considered in the light of modern educational theories, as pointed out by Dr. Weir, to be an educational weakness—the knowledge content still needs strengthening. Unless some adjustment can be made in the hospital nursing school to strike a better balance between nursing education and student nursing service, a satisfactory professional curriculum content may not be possible until the nursing school becomes an independent institution.

Provision for knowledge and skills have long been recognised as fundamental to any professional programme. A *third* objective is coming into increasing recognition. The curriculum must provide for the development of professional ideas and attitudes which are fundamental to successful professional service. It is not enough that a nurse has a scientific understanding, and that she can nurse her patient skilfully, but she must have the right attitudes in all her professional relationships. Professor Bagley in one of his books, "The Educative Process," states that the development of ideals and attitudes constitutes the chief work in

education. Attitudes are not developed by teaching them as such. They are a concomitant product of every learning experience: that is, with every intellectual response there is an accompanying emotional reaction. Likes and dislikes, and all the personality qualities, are built up in connection with every nursing activity. Because of this uncontrollable phenomenon within the student, it is of vital importance that the physical and intellectual environment to which the student is subjected should afford the most favourable stimulation. As Professor Bagley points out, it is the emotional spirit of the instruction which counts, and because of this belief, more and more emphasis is being placed on the personality elements in the selection of teachers. A curriculum remains a static thing until it is vitalised and humanised through the personality of an inspiring teacher. Is it not true that each one of us is indebted to a very great extent to some good teacher whose personality inspired the best in us? It was not the subject matter which was taught—that we have forgotten long ago!

A *fourth* basic factor in the educational requirements of a professional nursing school relates to the quality of the teaching personnel and the character of the teaching function. In all professions those who are shaping and directing the educational policies require the highest qualifications for professional leadership. This particularly applies to nursing at the present time, when the profession is being subjected to searching analysis. The head of a nursing school carries a wider responsibility than does the principal of any other professional school. Not only is she charged with the educational administration of the nursing school, but she is also responsible for the administration of the hospital nursing service. Directors of nursing schools today who are alive to this serious responsibility and who are aware of the growing educational needs of students, are demanding

whenever possible for their assistants, nurses with special graduate qualifications.

Dr. Weir points out the educational weakness of any professional school conducted by a teaching personnel who are not professionally qualified. He draws an analogy from the teaching profession, and states that if we hope to bring nursing schools to a recognised professional level we must accept the fact that teachers in schools of nursing must have special preparation in educational theory and practice, as is provided in normal schools for the professional preparation of public and high school teachers. The classroom teacher in schools of nursing today carries a heavy responsibility, not only in the number of subjects which she has to teach, but in the majority of situations she is largely responsible for the general organisation and function of the curriculum throughout the year. Dr. Weir again points out the educational weakness in situations where the whole teaching load is carried by one person; that is, no one teacher in any professional school could possibly be expert in the teaching of all subjects, and even if she were, she could not teach so many subjects efficiently. Normal schools have developed to the stage where there is a specialist, if not for each subject, for a group of correlated subjects.

Much is being said in relation to the place and function of supervision in education. Professor Burton, who is a recognised educational authority, in his book, "The Supervision of Instruction," defines most fully the scope and character of supervision in academic and professional education. In nursing education, the most fruitful and purposeful learning experiences are acquired on the wards, where the student comes in actual contact with her patient. These clinical experiences should be as carefully assigned, supervised, evaluated and recorded as are the classroom activi-

ties. Because of this growing appreciation of the importance of properly assigned and supervised clinical experiences, more attention is being paid to the adequate preparation of clinical supervisors. The head nurse is regarded as a clinical teacher, but because of her heavy administrative responsibilities she is unable to do all the clinical teaching. Consequently, the function of the modern supervisor is becoming largely one of teaching. The widening conception of nursing, with its increasing emphasis on social and public health aspects, the mental as well as the physical; its inclusion of prevention and health teaching; the increase of medical research, necessitating the institution of new nursing activities, demands that the preparation of the clinical supervisor should not only prepare her for her administrative function, but also for her wide range of teaching responsibilities. A school of nursing properly staffed with qualified teaching personnel has secured for itself the assurance that its classroom and clinical facilities are being fully utilised and that the students are being taught by recognised scientific methods.

The Survey Report lays particular emphasis on "education method" in the teaching function. Perhaps one of the most drastic criticisms of the educational system in schools of nursing which Dr. Weir makes is that relating to the function of teaching. He frankly states that in some nursing schools in Canada the teaching is of such poor quality that any educational achievement on the part of the student is acquired in spite of the teaching and not because of any purposeful guidance which the student receives. Some of the pictures which are presented of classroom situations suggest procedures which functioned in schools twenty or thirty years ago, before the introduction of the more modern teaching method. Educational research in the last ten years has opened up a new field of educational psychology and has established en-

tirely new theories upon which to base the technique of teaching. Experimental studies of the human organism have made it possible to determine, through educational measurements, the physical, mental and emotional differences of students, with sufficient accuracy to prove that teaching is a scientific process of specific and individual treatment. The two necessary factors in the teaching and learning process are a skilful teacher and a receptive student—and the curriculum is a means whereby the students grow.

Educational psychology has proved that "self-activity" on the part of the student is the basic factor in learning. Students must be encouraged to think for themselves rather than to accept passively the presentation by the teacher. Teaching means guidance, in the development of the student's mental growth, through definite psychological appeals rather than the more logical presentation of subject matter. Professor Bode, in his book, "Conflicting Psychologies of Learning," discusses the place and value of the psychological factors in the function of teaching. Professor Kilpatrick is an outstanding figure in his contributions to the field of modern educational theory and practice. He advocates stimulating and utilising the student's individual interests and making learning a "problem-solving" activity.

The study of the history of education shows that the acceptance of this scientific outlook toward teaching and learning has been a slow process. The older theory of instruction has been so ingrained in our school systems that there still remains much of its teaching practice, and in this respect nursing schools are particularly guilty. It is this defect which Dr. Weir projects when he says that students are "lectured at" rather than "taught." Dr. Weir observed seventy-five lessons in different schools of nursing, and upon these he based his judgments. As a critic-teacher, Dr.

Weir always has been credited with great diagnostic ability, so we are forced to accept his frank and rather scathing comments. As one reviews these criticisms, it would seem that there are at least two main reasons for so much weakness in the technique of teaching in nursing schools. Firstly, until recently courses have not been available for the preparation of nurses for teaching in schools of nursing. Until principals of nursing schools demand teachers with professional qualifications we cannot expect efficiency equal to that of a qualified teacher who has a scientific appreciation of modern educational theory and method. In making this statement we are not forgetting the splendid work that has been done, and that is still being done, by teachers in schools of nursing who have not had special preparation. Secondly, the classroom teacher is struggling against time. She is confronted with the different courses to be covered in a limited period. This time allotment does not permit of thought-provoking questions nor for reflective thinking on the part of the students. The teacher must resort to the most expedient method of interpreting her subject, namely, the "telling" or the lecture method. This criticism has special application to the limited period allowed for the efficient teaching of nursing theory and practice. It is the major subject in the curriculum; it is the pivot around which all other subjects revolve, and to which all others are subordinate. To those who are concerned with curriculum organisation, there are two considerations of pedagogical importance to be kept in mind: (1) the careful evaluation and selection within the course of what is to be considered as essential subject matter, (2) adequate provision of time for efficient teaching.

Dr. Weir lays special emphasis on "student participation" in learning and criticises the preponderance of the lecture method which characterised the teaching he observed. He

presents a unique exposition of the values of case study method in teaching. The case study method is being universally adopted in professional schools as a method which affords the most purposeful learning. It is a recognised method of education in law, medicine and social service work, and it is becoming recognised in schools of nursing. It has many advantages as a method of effective teaching. The case study method provides a situation which stimulates the student's interest, develops her powers of observation and scientific thinking, and closely correlates theory and practice. It develops a sympathetic relationship between student and patient, in which the student sees the patient not as a pathological hospital case, but as a member of society who is entitled to health and happiness; that is, it helps to develop the social and public health point of view in nursing. It is defined as a method which puts real life into education, as well as real education into the student's

life. The possibilities of the case study method are well recognised in education today, and should be adopted in all schools of nursing as a method of clinical teaching. There are, however, several difficulties to be overcome in our present system of nursing education before this method can function successfully. The case method of teaching can only be successful in the hands of skilful teachers and when undertaken by students with at least normal intelligence.

In conclusion, it might be stated that a résumé of Dr. Weir's recommendations affecting the educational status of nursing schools will reveal the fact that these recommendations relate not only to the educational facilities which should be made possible through public recognition and support, but that they refer particularly to the professional qualifications of the teaching personnel within the school, upon whose direction will depend the whole character and quality of the educational programme.

MISS NORA NAGLE RETURNS TO CANADA

An appointment of interest to Canadian nurses is that of Miss Nora Nagle to the staff of the nursing department at the University of Toronto. Miss Nagle, who is already well known to many of our readers, comes to her new work with very high qualifications; training and experience both at home and abroad have combined to produce a depth of understanding and judgment that are greatly needed by our nursing schools in these difficult days. Miss Nagle received her early training in nursing at the Royal Victoria Hospital, Montreal, and subsequently has held positions on the staff of several hospitals, including Mt. Sinai Hospital, New York; Hamilton General Hospital; Evanston Hospital, Evanston, Illinois, and the Ottawa Civic Hospi-

tal. To this she has added post-graduate study at Teachers College, obtaining there the B.Sc. degree in Columbia University, New York City, 1928, and M.A. in 1930. During the years 1928-1931 she was on the staff at International House, New York, serving as Health Advisor.

Miss Nagle's appointment foreshadows the expected reorganisation of the courses in nursing at the University of Toronto. The work there has outgrown its present resources and the present form of organisation, therefore plans are now under way for developments which will come into effect in 1933.

We offer a very warm welcome to Miss Nagle as she returns to her own country after several years of sojourning abroad.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

Group and Hourly Nursing

By MARY HALL CAVANAGH, Victoria, B.C.

The nursing profession today, like every other occupation, is faced with the problem of over-production. We have in the past turned our nurses like machinery from training schools all over Canada, irrespective of their being suited for the profession or not.

In order to eliminate this barrier, we must concentrate on the needs of the working classes, who, after all, are the back-bone of the country. In the past, the nursing profession has been kept active to a great extent by the monied classes. During the past three years the whole world has experienced perhaps the greatest financial crisis in history, and the nursing profession is faced today with the problem of finding work for the graduate.

At the present time the nursing profession has one class of nursing—that of individual specialling for those who want the exclusive attention of the graduate, but the present-day conditions warrant at least three classes of nursing.

First: Individual specialling.

Second: Group Nursing, the only possible means of eliminating the unemployment among our graduates. Group Nursing, to my mind, is one of the most human and sane ideas we have entertained. It will be of considerable benefit to the working classes. A patient will consider dividing the graduate's time with another

patient and willingly pay the sum of \$2.50 a day. Whereas the sum of \$5.00 would be entirely out of his means.

Nurses, I feel sure, would be much happier in their work attending to two or three patients instead of one. In many cases of individual specialling the graduate's valuable time and knowledge are lost.

Another feature of Group Nursing would be the special attention the graduate would give to the nourishment and meals for her patients: this, to my mind, is a very important feature, as in many cases the nurse in training has not received her dietetic training, nor has she, in many cases, the time to prepare a tempting dish for the patient when he so desires it.

Third: Hourly Nursing. I also favour Hourly Nursing. There are many chronic individuals in homes who really do not need the entire time of the graduate nor that of the practical nurse, but would gladly welcome the idea of the hourly nurse, who would come in, give the patient any treatment the attending physician prescribes, sponge bath, change of linen, once or twice a week or as often as the patient so desires.

Registration of Nurses

Under the new proposed system of nursing it would be advisable to have three distinct grades of nursing:

1. Individual specialling.
2. Group Nursing.
3. Hourly Nursing.

This system should not in any way interfere with the present form of registration: I mean from the point of view of the registrar. The registrar will have the nurses listed under the proposed classifications, so that when a nurse registers for duty she simply states what she wants—either any of the three groups or just one. The question might arise as to whether or not it would be advisable for the hospitals to be responsible for the calling of nurses for group nursing.

The question has arisen as to the building of hospitals to meet the requirements of the proposed system of group nursing. To my mind, the idea is impracticable. A nurse can give unlimited attention to two or three patients each in separate rooms, but

discretion must be used as to the condition of patients. In a case where patients are quite ill, the "group nurse" should not be responsible for more than two patients. Also, I would not advise more than two maternity cases at a time for the "group nurse."

I feel that "Hourly and Group Nursing" will become most popular from a public point of view, also from that of the graduate. I can see no barrier in the way of success for the nursing profession under the proposed systems, but in order to attain success the entire medical profession must enter into it whole-heartedly. After all, it is greatly to the benefit of surgeons and physicians, and a happier public spirit toward our institutions will be realised.

Group Nursing

By CHRISTINA TODD FOSS, Winnipeg, Man.

Group Nursing was introduced into the Winnipeg General Hospital in October, 1929, on a women's semi-private flat, devoted to surgical cases only. Upon admission to hospital the patient or relative interested was given an explanatory circular. The supervisor of this floor was made responsible for the operation of the plan, under the direction of the superintendent of nurses and the superintendent of the hospital.

The reason for the experiment was two-fold: to benefit (1) the patient, (2) the private duty nurse. The patient benefits by having the opportunity to secure experienced care on a part-time basis at less than half the cost of employing a day and night private nurse. The nurses benefit by obtaining steady employment with an assured income.

The plan was begun and is still operated under the following arrangements: There is a unit of four patients and three graduate nurses. Each day nurse is responsible for two patients, and one night nurse responsible for the four. The patient's fee for this twenty-four-hour service is \$5.00 per day, in addition to the ward charge, with no extra charge for nurses' meals and payment made directly to the hospital. The patient is free to go off "Group Nursing" service at the end of any twenty-four hours. If the patient's condition is such that the continuous presence of a nurse is required, the floor supervisor has the privilege of suggesting to the doctor or relatives that the patient is too ill for group nursing, and in all probability a special nurse will be arranged for that case. When

the patient feels well enough to do without "Group Nursing" she is put under care of general floor duty.

The nurses are employed and paid by the hospital and have to be experienced. The salary is \$95.00 per month. Hours are from 7 to 7, and nurses are on duty eight and one-half hours a day (exclusive of meal hours and two hours' rest), and have two weeks' night duty alternating with four weeks' day duty. A half day a week off duty is allowed. During one nurse's time off the other nurse takes charge of the four patients. At nights the "group nurse" chooses the quietest period of rest hours, leaving the floor nurse in charge, under the direction of the night superintendent. A month's vacation with salary is given at the end of a year, providing the nurse intends to continue the work. The group nurses are considered part of the nursing staff of the hospital and enjoy its privileges, with the exception of living in residence.

Upon occasion a substitute may be obtained if approved by the hospital and paid by the nurse.

Group nurses are required to assist on the floor when not fully occupied with "group patients," and as sometimes it happens there are no patients

under this plan, the group nurses may be sent to any other part of the hospital in need of help.

The above plan, with a few minor changes, has continued in operation at the Winnipeg General Hospital for two and a half years, and is becoming increasingly popular among the patients. Apparently, financially it is just paying its way. The nurses employed are glad of steady work, and while, of course, it does to some extent take cases away from special nurses, it gives experienced care to patients who simply could not pay the higher rates of private nurses, and more continuous employment to those taking part in group nursing. As a means of affording better distribution of employment during the present depression, one of the appointments to this service is of a temporary nature, the nurse changing every two months.

For its success a good deal of credit is due to the foresight of the Superintendent and the co-operation on the floor between the group nurses and the supervisor. And speaking from two years' experience as one of the first group nurses, I see no reason why the plan should not continue in popularity and financial independence.

"The principles of Miss Nightingale's teaching are as true today as when she advanced them seventy years ago, because they are the fundamental laws of health. The great nations of the future will be the people who love knowledge—no ignorant nation will stand in the fierce economic struggle. Let us therefore adopt an educational scheme to make more efficient the trained nurse, the nucleus of which we have already organised in the International Students' training Course, a scheme in which nurses from all over the world can participate and which will edu-

cate them in the higher branches of administrative work and public health. We have come together today for co-operation, amalgamation, and progress, to found not a museum or memorial of stone, but a forceful and useful organisation, in constitution simple and yet effective, whereby all humanity may benefit."—Mrs. Bedford Fenwick's concluding remarks in her address at the Inaugural Meeting of the National Florence Nightingale Memorial Committee of Great Britain.—*The British Journal of Nursing*, August, 1932.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,

MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

Chairman's Address

By MARGARET MOAG, Montreal, P.Q.

It is very interesting to see so many of our public health nurses from all parts of Canada gathered together in this province by the sea for this Sixteenth General Meeting of the Canadian Nurses Association. The past two years have been very difficult ones, for economic depression, with consequent unemployment, has taxed the efforts of all health and social agencies in every community. All health programmes have been endangered, yet never were the services of qualified public health nurses so essential or the health needs of the communities so apparent.

Co-operation, which has always been of vital importance, would seem to be the keynote of community work at present, for health workers and social workers are greatly dependent upon each other in this national extremity. Volunteers never were so eager for opportunity for service previously, and while we recognise the difficulty of finding time in an already overburdened programme to teach and interpret our work, is it not worth while to make the effort, remembering that the volunteer of today may be the future board member, and is, if not already, *the potential taxpayer*? Health workers in every field pass on, through time, to wider fields of service or otherwise, and in the last analysis the governing lay body is responsible for seeing that the community needs are met; hence the necessity of their education and understanding of public health work. Books and pamphlets, outlining stan-

dards and principles of public health nursing, are available today, and may be easily read and understood by lay members, with some assistance through conferences with the health worker. We must remember, too, the actual contribution these lay people will make in interpreting public health nursing to the public in general.

There are many interesting developments to be reported upon by the secretaries of the public health sections of the different provinces, so we will mention briefly a few outstanding ones.

Maternal Mortality: The reasons for maternal mortality are being thoroughly investigated by our leading physicians and we look forward to enlightening reports and constructive recommendations in the near future. Maternal institutes for nurses have been organised and conducted in various centres by the Victorian Order of Nurses for Canada, so that the essentials of maternity care may be emphasized and value noted by those attending.

Nutrition Work: New, live interest in the relation of nutrition to health is being awakened, and the value of the nutritionist is stressed in every public health programme. Not only is her teaching and supervision of the ante-natal mother of vital importance to the health of the coming generation, but her advice regarding food and nutrition for the whole family is taking a definite place in health education. When the family income is limited, here, too, her service is invaluable, as she teaches how expenditures of food may be planned in

order to obtain the greatest food values for the least money.

Mental Hygiene: Preventive medicine points out the value of mental hygiene in every health programme and of the necessity of its application by the visiting nurse in the home.

Health Insurance: The present economic situation has stimulated the efforts of progressive citizens to interest our governments in the necessity of unemployment and health insurance, and we have reason to believe it is only a matter of time until these are realities throughout Canada. Socialisation of nursing will eventually follow these two developments, so that skilled nursing service will be available at reduced costs for everyone requiring it.

Survey: Perhaps the most outstanding development is the completion of the Survey of Nursing Education in Canada. It has provided our Section, as well as all others, much food for thought and study during the next two years. Public health nurses throughout Canada must familiarise themselves with the needs as shown in the Survey Report in order that they may effectually assist

in working out the recommendations made therein. Each nurse has a duty to perform in educating the lay people, who are eager to know what it is all about, and she can only do this to the extent that she herself is informed and understands.

Present and Future: This great epidemic of unemployment and consequent misery in the lives and homes of so many of our Canadian people rather obstructs our view of the future. Lower appropriations and reduced staffs tend to discourage even the most optimistic. Many are concerned because we cannot continue with the finer points of the structure we have been striving for years to attain. Let us not be pessimistic, but strongly endeavour to see that our foundations of high standards, sound technique and well prepared personnel remain firm.

We hope that our sessions will be interesting and stimulating for us all, and that we will return to our several duties with more knowledge, fresh courage and stimulation, for the part we play in the prevention of disease and the promotion of health throughout our great Dominion.

Survey of Nursing Education in Canada—The Implications for Public Health Nurses

By EUNICE H. DYKE, Director, Division of Public Health Nursing,
Department of Public Health, Toronto, Ont.

These remarks include nothing that we have not said or thought—many of us. My lot is to present the point of view in a formal paper.

With fifteen minutes at my disposal to present the topic assigned, it is necessary to choose from among the many "implications of the Survey for public health nurses." I have chosen one. Other nurses who will discuss the topic may use their time to modify my statements or may pre-

sent other implications which they consider equally important.

The clear message of our Survey of Nursing Education is that Canada has permitted the hospital rather than the community to dominate the nursing profession, and to leave the nursing services of the community unorganised. Since the public health nurses touch all phases of the community and understand its needs as no other nurses of today can be expected to do, their answer to that message must be that they will accept responsibility for interpreting the

(Read at the Public Health Nursing Section, Canadian Nurses Association General Meeting, June 23, 1932.)

community needs to their profession. Upon them *at this time* must fall the burden of leadership for the nursing profession and nursing.

All public health nurses are not community-minded, and community-minded women are found among hospital superintendents and private duty nurses. The vision of many hospital superintendents has been the strength of the public health activities in their communities. The exaggeration of the painter rather than the accuracy of the photographer is evident in my statement that the burden of leadership must fall at this time upon the public health nurses.

Leadership of the nursing profession and nursing by the public health nurses calls for a change in their attitude to the superintendents of hospital nursing and of the hospital school. The majority of the hospitals isolate the superintendents of nurses during their years of training and their years of responsibility from the community for which nurses must be prepared and from which hospital patients come. Public health nurses will continue to honour the hospital executives, but in the light of Survey findings we cannot continue to expect them to determine what nursing services and the preparation of nurses for the community shall be.

The public health nurses' attitude to the private duty nurses will be changed by the Survey. The private duty nurses are identified with an important section of the home life of the community. The Survey suggests developments in the organisation and employment of private duty nurses which involve united thought and action between public health and private duty nurses. As a result of the Survey, more interpretation of community needs and co-operation in organising community services will be expected from private duty nurses than has been expected in the past.

The identification of the public health nurses with the community has

been developing bonds with teachers, social workers and civic leaders—bonds which are frequently closer than those with their own profession. A common origin has held public health nurses by sentiment to the institutional and private duty nurses, but they are *not* sharing their interests with other nurses to the extent that they share them with teachers and social workers. Since the motive power for the entire nursing profession should be community rather than hospital needs, the public health nurse is called upon to share her community contacts with the more isolated members of her profession.

The Report of the Survey reflects the modern public health movement in its application to the term "health services" to the care of the sick in hospital and homes as well as to the special services created for the prevention of disease and the maintenance of health. The unity of research, professional education and the varied services having as their purpose the care of the sick, the prevention of disease and the maintenance of health, characterises modern public health thought. The public health nurses, whose contact with homes rather than sick individuals impresses them with that essential unity, recognise the value of united thinking on the part of hospital, private duty and public health nurses. A *united nursing profession* would support similar movements within the medical profession and the sound development of all forms of community organisation for the advancement of health standards.

Assuming that the hospital rather than the community has dominated Canadian nursing in the past, that the public health nurse must, as the result of her wide community contacts, accept leadership for the nursing profession, and that her leadership will result in unity of effort among all nurses concerned with the care of the sick and the maintenance of health, we shall proceed to consider what the public health nurses' leader-

ship of the nursing profession might involve.

The obligation of leadership from public health nurses is not limited to the committees of national and provincial nursing associations or to members of conspicuous organisations. The leaders in all phases of our national life come, as a rule, from the smaller communities. In the town with one hospital, a handful of private duty nurses, trusted practical nurses, friendly neighbours, and a few public health nurses whose services are not broken up into artificial specialties, a unity of community thought and effort can be developed which is difficult under the isolating conditions of the large cities. The legislative assemblies respond to the trusted advisors from home towns, and a united home-town nursing group will win their confidence. Upon legislative changes depend the reorganisation of nursing schools and nursing services, and those legislative changes may depend upon a united nursing profession in the small towns of Canada.

The recommendations of the Survey are directed towards the establishment of nursing schools which are financed by and responsible to the community. Sound teaching methods would be developed by these schools and nurses produced which the community would employ at adequate salaries. The recommendations are directed, also, towards the organisation of nursing forces on a basis which would be acceptable to the public and to the nurses themselves. What contribution might public health nurses make towards the attainment of these ends?

1. The first effort of the nursing profession must apparently be to convince legislative assemblies that progress in overcoming present dissatisfaction with nursing services depends upon the creation of schools which are independent of hospital control, although making use of selected hospitals as teaching fields. The approach of hospital finance and administration

is not enough. The questionable value of the product of the present hospital schools needs publicity which the public health nurse can provide through her varied community contacts. Constructive criticism of the hospital school as one cause for her own limitations might be effective.

2. In order that the public health nurse may gain experience in preparation for membership on the staffs of the nursing schools of the future, and in order to plan with present-day hospital schools for future developments, the public health nurses might join with nurse instructors and head nurses in their study of the present lectures and practical experience provided for hospital students. That co-operative study might lead to requests for the public health nurse to give lectures and provide practical experience for the hospital student. The least result to be hoped for would be a changing emphasis in the selection of students, the lectures, and the practical experience for which the staff of the hospital school is responsible.

3. The membership and programmes of local nursing associations might be influenced more strongly than at present by the public health nurses of a community. These organisations afford opportunities for group thought which would strengthen the teaching of the hospital school and the organisation of nursing forces. It is important that these local associations include hospital, private duty and every variety of public health nurse, and that the programmes should enlist the younger nurses from all three groups.

(a) A typical question for conference between the three groups might be whether the hospital school should teach the student to bathe the baby on a table or on the knee. This apparently trivial question involves the consideration of household equipment and family life which should influence the teaching of the hospital school. A study of the relationship of a pa-

tient's family to the hospital might lead to more use of telephone interviews and visiting hours for teaching purposes. A demonstration by a hospital dietitian of the use which can be made of the food provided by public relief agencies for the families of the unemployed would modify the hospital course in dietetics.

(b) A topic for debate in local nursing associations which would stimulate thought directed towards the organisation of community nursing forces would be: "Resolved that each branch of the Victorian Order of Nurses should employ a second group of salaried nurses to provide resident nursing care in the homes." Canada *may* have in its semi-official national nursing organisation (the Victorian Order of Nurses) the answer to the growing demand for a socialised system of nursing care for the sick. It may be that the evidence of the Survey regarding the distribution and employment of nurses calls for the development of the Victorian Order rather than for the district registries as a function of the nursing councils which are suggested in the Survey Report. Some local nursing association, with representatives from hospital, private duty and public health nurses, may be able to reduce, to the simplest terms, the problem of distribution and employment of nurses for consideration by the Canadian Nurses Association.

Many years ago, when I was still under the spell of the training school atmosphere, I was sympathising with a hospital superintendent over certain petty destructive criticisms from members within a nursing association. I remarked that the trouble with our profession was that we would not grant loyalty to our responsible leaders. She replied that the weakness of the majority of nurses was an unwillingness to lead. The years have taught me that she is right. We produce few leaders within

our profession in comparison with our numbers and very few for important community services, which are suffering from the lack of the insight our profession might bring. The atmosphere of this conference is not the atmosphere in which the majority of us carry on our daily work. Whenever we acknowledge the weakness to members of our own profession or to protesting co-workers, the reasons given are usually our age-old subordination to the medical profession and the training school attitudes. The evidence of the Survey suggests other distressing causes. Possibly the paralysing influence which has resulted in our confessed weakness is that the nursing associations have not recognised an objective strong enough to unite their divided interests, an objective which is strong because it supersedes our personal and professional concerns. The Survey presents that objective: the community and its needs.

The vision of leaders among our hospital superintendents has encouraged the development of qualities of leadership among public health nurses. Today we have a president and a secretary from that group. The time may come when our local, provincial and national officers will be community nurses in the truest sense, whether they come from private and public health organisations, from private practice, from hospital wards and offices, or from schools of nursing. That time will come when the nursing profession is dominated by community needs and works unitedly with other professions and the public for the advancement of health standards in Canada.

When the next Survey of Nursing Education in Canada is completed we will acknowledge more fully our debt to Dr. Weir and the Survey Committee of today for the honesty with which they have presented the facts of the present situation for our guidance.

*Florence Nightingale—A Review**

By JEAN E. BROWNE

So many books and articles have been written and so many speeches have been made on the life of Florence Nightingale, that one's involuntary reaction to a new life is a rather pensive, or shall we say peevish, sigh. But to read Irene Cooper Willis's recently published book is to take a fresh start. One sees Florence Nightingale almost as a new and vibrant character, through the clear and penetrating eyes of this biographer.

So much sickly sentimentalism has been built up around the story of this great woman—the kind of thing which she herself so heartily despised—that it is refreshing to find an analysis of her character made with honesty and understanding. And this in no way diminishes the splendour of her qualities, but it reveals to us a real person in whom we can believe, rather than a mythical being crowned with a halo of sanctity.

The author makes a great point of throwing up Florence Nightingale's "insatiable public spirit" in high relief against the social background of the first half of the nineteenth century, when public spirit was deplorably lacking. "The Industrial Age had brought social problems with it, to grapple with which there was neither experience, policy nor administrative machinery." To get this background more clearly fixed the reader should refer to an account of the rise of Luddism and to the later Chartist Movement in England. Florence Nightingale was born in this period, when the world was only just beginning to have a conception of its social responsibilities, so it was little wonder that she had to engage in a really terrific struggle to emancipate herself from the traditions of her class. But because of her indomitable will and energy, she did break loose from these bonds. Strangely enough, although she herself was by far the most outstanding example of "woman's rights," she never allied herself very closely with the suffrage movement.

Having analysed the elements of Florence Nightingale's character, there still remains the necessity to account for her almost Napoleonic power in England during and after the Crimean War. Public opinion, roused to horror by the accounts of the horrible sufferings of the wounded soldiers in the Crimea, was the element which brought her efforts such quick results, and which placed her on such a dizzy pedestal. "If there had been no war, she might have worked throughout her long life transforming nursing and reducing the heavy mortality rate and toll of pain in illness, but her work would not have received quick recognition. . . . In the usual course of events, the powers that be

hold their own against any outside criticism. But in war-time, there are certain themes the merest touch upon which causes national emotions to rock with hurricane strength, and one of these, naturally, is the welfare of the army. . . . Florence Nightingale, the greatest comfort the British Army had ever known, had, therefore, as far as public opinion was concerned, a 'walk-over' in her match against professional prejudice."

Those who write the history of Military Medicine are apt to be out of sympathy with Florence Nightingale's revolutionary work for the care of soldiers. Yet certain facts, clearly brought out by the writer of this volume, can not be side-tracked. There is incriminating evidence that the head of the Army Medical Department and the Principal Medical Officer at Scutari declared over and over again that nothing was wanted—and this in the fact of the most appalling lack of even the barest necessities of cleanliness and sanitation, to say nothing of comfort. Also, in the instructions issued by the Principal Medical Officer, there was a definite caution to Medical Officers against the use of chloroform in operations with the explanation that "it was better the hear a man bawl lustily than to see him sink silently into the grave". The mischief lay in the fact that army administration had not been looked into for forty years, that more than half a dozen separate departments had to do with army matters, that their various functions had never been co-ordinated, and that no single authority appeared to be able to exercise full control. Consequently, even when supplies were sent, it was impossible to get at them without tedious delays. One can readily imagine how a practical and merciful woman would chafe at such inefficiency, and how she was unsparing of her exposure of all those who stood in the way of effective care of the wounded. Expose them she did with a thoroughness which in time led to a complete reorganisation of the British Army Medical Corps.

Her reorganisation of nursing in England after the Crimean War is a somewhat similar story. The chapter on "Hospitals, Nurses and Statistics" cannot fail to be of compelling interest to all who are concerned in the development of nursing. Again, she encountered the antagonism of the medical profession. Dr. South, the senior surgeon of St. Thomas's, wrote a pamphlet attacking the new school of nursing. "He declared that the proposed school was quite unnecessary, that statements about nursing inefficiency were quite untrue, and that the old-fashioned nursing was excellent and was satisfactory to all physicians and surgeons, as was shown, he said, by the fact that out of ninety-five physicians and seventy-nine surgeons in the seventeen London hospitals, only three physicians and one surgeon from one hospital

(*Florence Nightingale, by Irene Cooper Willis, published by George Allen & Unwin, Ltd., Ruskin House, 40 Museum St., London, England. Price, \$2.25.)

and one physician from another had supported the scheme." No doubt the other 169 were prototypes of the reactionary medical men of the present day.

The author states that Florence Nightingale had a passionate belief in statistics. The epigrammatic style of the following paragraph is typical:

"Like Moses, Florence was a great law-giver. I fancy, however, had she been in Moses' place, she would have made short work of those wanderings in the wilderness; I think she would have got the Israelites into Canaan, by hook or by crook, in much less time than forty years. She would not have thought it necessary to toil up Mount Sinai to procure from Jehovah the Ten Commandments. She would have promptly established a department of statistics as an annex to the Tabernacle and from an exhaustive study of its data she would have deduced the laws of the universe."

After her School of Nursing was well started, Miss Nightingale turned her attention to Reform in India. Her great personal friend, Dr. Jowett, gave her the following title:

"Florence the First, Empress of Scavengers, Queen of Nurses, Reverend Mother Superior of the British Army, Governess of the Governors of India".

But whatever activity occupied her attention, she was known to be a person who got things done, and who did not mince her words. "You may think I am not wise in being so angry," she wrote to Sir James Clark in 1864, apropos of a correspondence she had been having with the War Office. "But I assure you, when I write civilly, I have a civil answer—and *nothing is done*. When I write furiously, I have a rude letter—and *something is done* (not even then always, but *only then*)."

The book ends on the note of her favorite hymn, "The Son of God goes forth to War," and the author's closing words are well-chosen indeed. Following a few bars of the music of this well-known hymn is the commentary "How few the notes! What fervour they carry! So it was with Florence's life. A few strong notes—no deviation from the scale of them; no elaboration of theme—faith, ardour, singleness of purpose, great Victorian qualities, filled out and quickened by a battle imagery, tense with fighting appeal."

Catholic Hospital Association

An excerpt from the Resolutions unanimously adopted at the closing meeting of the Catholic Hospital Association of the United States and Canada at its Seventeenth Annual Convention, Villanova College, Villanova, Pennsylvania, June 21, 1932:—

"BE IT RESOLVED, That this Association reaffirm its repeated indorsements of all programmes formulated by its sister organisations for the progressive advancement of nursing education.

"BE IT FURTHER RESOLVED, That this Association hereby reiterate the confidence expressed by the Sixteenth Annual Convention that a formulation and development of criteria of educational excellence is a responsibility which our own organisation cannot escape in view of the present national status of nursing education.

"Specifically, therefore,

"(1) This Association hereby endorses the programme already undertaken by its Council on Nursing Education aided by the newly created Advisory Committee;

"(2) This Association requests of the Council the further study of a number of special problems, the existence of which and the need of a solution of which have been specially called to the attention of the Association in the course of the present Convention. Among these problems are:

"(a) The formulation of an administrative and instructional terminology suggestive rather of the educational institution

than of the apprentice training in the development of the nurse;

"(b) The further development of all the fourteen criteria of excellence formulated by the last year's Convention;

"(c) The further development of the informational and instructional service of the Association as an aid to the individual schools seeking the Association's counsel;

"(d) The more complete study of the affiliation of our schools of nursing with accredited colleges and universities and the formulation of principles which will safeguard the use of such affiliation in the more effective education of the nurse;

"(e) The further development of a programme looking towards a more extensive use of hospital affiliation for the purpose of supplementing the deficiencies in the curriculum of individual schools of nursing and the development of closer relationships between the schools of nursing and public health agencies for the purpose of affording a much-desired measure of public health experience in the nurse's educational programme;

"(f) A more extensive study of the true scope of nursing education with its various sub-divisions, together with information concerning centres of education for various classes of nurses.

"Approved:

"STEPHANIE M. -----

"President"

News Notes

Contributors to this department of the Journal are requested to note that **after November first** all copy should be addressed to 401 Crescent Building, Montreal, Quebec, the new headquarters for the Canadian Nurses Association.

MANITOBA

GENERAL HOSPITAL, WINNIPEG: Miss Ella McKechnie (1927) was to sail the end of August for India, where she will join the staff of the Gwalior Mission Hospital at Shausi. Miss Beulah Bournes (1929) was to sail for Korea on August 27, 1932. She will take charge of a Mission Hospital at Hamheung, Korea. Mrs. Harry Williams (Kate McKellar, 1925) and her husband have returned from China on furlough. Mrs. R. Emmett (Isabel Hamilton, 1919) has returned to Winnipeg after spending the past three months in England and on the Continent. Misses Fannie Clegg (1932) and Margaret Finlay (1928) relieved on the staff of the Social Service Department, W.G.H., during the summer months. Miss Winnifred Stevenson (1927) visited in Vancouver and Victoria during July. The following graduates visited in Winnipeg during the summer: Mrs. T. Nesbitt (Flora Lawford, 1906), Chicago, Ill.; Miss Marion West (1930), Boston, Mass.; Miss Elizabeth Pearson (1924), Grande Prairie, Alta.; Miss Lillian MacAuley (1919), Port Arthur, Ont.; Miss Beatrice Creasy (1929), Toronto, Ont.; Mrs. Robert Richardson (Helen Hallaway, 1925), Chicago, Ill.; Miss Nan O'Grady (1925), Vancouver, B.C.; Mrs. John Kniper (Bessie Bennett, 1925), Lexington, Kentucky; Miss Clara J. Forbes (1929), Brantford, Ont.; Miss Jean Whiteford (1924), Kitchener, Ont.; Mrs. Paul Merritt (Violet Neelin, 1928), Marion, N.D.; Miss Mabel F. Gray (1907), Vancouver, B.C.; Miss Janet Smith (1928), Belleville, Ont.; Miss C. Lynch (1925), Ponoka, Alta.; Mrs. Purdy (Olive Patrick, 1920), Kingston, Ont.; Mrs. Minnie Gardner (1925), Detroit, Mich.; Miss Elva Pringle (1929), Ann Arbor, Mich.; Miss Ann Goodwin, (1929) La Porte, Indiana.

NEW BRUNSWICK

MIRAMICHI: The members of the student government of the Miramichi Hospital, accompanied by members of the faculty, held a very enjoyable beach party on Monday, August 15th. The party motored to Bay Du Vin Beach, where many indulged in swimming, while the others went for a stroll along the beach. A pleasant sing-song around a cheery bonfire on the beach brought the pleasant evening to a close.

ONTARIO

LEGISLATIVE AMENDMENT

The Registration of Nurses Act, 1922, was amended on February 21st, 1929, by adding the following words:

"And no nurse shall be considered in good standing in the Province of Ontario, or as a Nurse registered under the Registration of Nurses Act, 1922, and entitled to use the designating letters 'Reg.N.' after her name unless she has paid the prescribed fee for the current year. Failure to pay the fee for the current year on or before the date specified in the Regulations, namely, the first Monday in February, shall automatically suspend the registration and also suspend all rights and privileges enjoyed under such registration. Suspension so incurred may be revoked on payment of all arrears in this respect and on presentation to the authorized Nurses Registration Branch of the Department of Health, of a satisfactory reason for failure to comply with the Regulations."

Paid-up subscriptions to "The Canadian Nurse" for Ontario in August, 1932, were 976, nine more than in July, 1932.

APPOINTMENTS

Miss Christina McLaren, formerly of North Bay, has recently accepted the appointment of Assistant Superintendent of Nurses at Strathroy General Hospital.

Miss L. McTague (Kitchener and Waterloo Hospital, Kitchener, 1921) has accepted the position of assistant superintendent, and Miss Wilda Pollock (1923) as supervisor at the Kitchener and Waterloo Hospital.

Miss Aubra Kathleen Cleaver has recently taken up her duties as superintendent of the Galt General Hospital. Miss Cleaver's home is in Burlington, Ont. She is a graduate of the Toronto General Hospital, 1923. Since graduation Miss Cleaver has spent two years in industrial nursing service, three years in Red Cross Out-Post Hospital service at Dryden and New Liskeard, and two years on the staff of the Toronto General Hospital. Miss Cleaver has recently completed a course for administrators and teachers in Schools of Nursing at the University of Toronto.

Miss Agnes Campbell is now superintendent of the Guelph General Hospital. She is a graduate of the Toronto General Hospital, Class 1912, and after graduation was on the staff of that institution, later serving overseas with the University of Toronto Unit No. 1. Formerly superintendent of nurses at the Saskatoon City Hospital, Miss Campbell took a course at McGill University to prepare herself for hospital and training school administration.

DISTRICTS 2 AND 3

An executive meeting of Districts 2 and 3, R.N.A.O., was held at the Freeport Sanatorium, Kitchener, August 17th, 1932. Those attending were Misses H. Booth, A. Weber, H. Herr and Jessie M. Wilson.

DISTRICT 2

GENERAL HOSPITAL, BRANTFORD: Miss Lavinia Gillespie and Miss Dora Arnold of the nursing staff are on vacation. Miss S. Livett has returned to the Brantford General Hospital after spending a month in Galt. Miss Jessie Edmondson entertained a few friends most enjoyably in honour of Mrs. Sketetee, *nee* Miss M. Hall, whose marriage took place recently at Grand Rapids, Michigan. Miss E. M. McKee, superintendent, Brantford General Hospital, is spending her vacation in Montreal. Miss E. M. Jones spent an enjoyable holiday at Fenelon Falls, Kawartha Lakes. Miss L. VanEvery (1932) is supervising in the operating room during the absence of Miss Hilda Muir, who is on vacation. Miss M. McCormack (1925) has returned to the Stevenson Memorial Hospital, Allison, after holidaying in Brantford. Miss G. Turnbull (1927) spent a short time recently in Detroit, Mich. Friends of Miss M. Wentworth (1932) will be pleased to know that she has recovered sufficiently after her recent operation to return to her home. Miss G. Moyer (1930) relieved for the V.O.N. during the month of July. Miss A. Mair (1926), of Brooklyn, N.Y., is on vacation at her home in Brantford. Miss M. Gillespie (1915) has returned after a motor trip to Ottawa and Owen Sound. Miss P. Cole spent an enjoyable holiday at her home near Owen Sound. Miss I. Marshall (1924) spent her vacation in Detroit, Mich. Miss Florence Kudoba, Stratford General Hospital, was a recent visitor at the Brantford General Hospital.

STRATFORD: Miss M. E. Gibb, assistant superintendent, Stratford General Hospital, sailed aboard the S.S. "Duchess of Atholl," on a six weeks' trip abroad. The Nurses Alumnae Association entertained the recent graduating class at a dinner party, held at the Windsor Hotel, at the conclusion of which the guests and members went to the theatre, thus completing an enjoyable evening.

KITCHENER: The new wing of the Freeport Sanitarium, Waterloo County, was formally opened on Thursday, July 28th. Premier Henry and Hon. Dr. Robb officiated at the opening ceremony. Miss E. Bingemen and her nursing staff assisted Dr. and Mrs. Coutts in welcoming the guests. Tea, arranged by the Ladies' Auxiliary, was served in the new building.

GALT: The Board of Commissioners of the Galt General Hospital have, after careful consideration, decided to discontinue the nursing school and to provide a graduate nursing service, from graduates of Galt General Hospital; approximately twenty will be employed. Miss A. M. Munn, Inspector of Schools of Nursing, Province of Ontario, will place the students already in the school. The entire junior class will be transferred to the Brantford General Hospital on October 1st. These nurses will receive the pin and diploma of the Galt General Hospital at the completion of their training.

GUELPH: Miss Galloway and Miss Armstrong, of General Hospital, Brooklyn, N.Y., and Miss Brown, of Public Health Department, Hamilton, Ont., were recent visitors at the Hospital. Dr. W. J. R. Fowler, Chairman of the Board of Commissioners, entertained the staff and students recently at his beautiful home on the Kitchener Road. Miss Stockford, instructor at Presbyterian Hospital, Philadelphia, was a visitor recently at Guelph General Hospital. Miss S. A. Campbell had her sister, Miss Beatrice Campbell, visiting with her a short time ago en route from London, England, to Winnipeg, Man.

DISTRICT 5

THE HOSPITAL FOR SICK CHILDREN, TORONTO: The fifth annual dinner of the Alumnae Association was held on Monday evening, June 6th, 1932, at Eaton's Round Room.

Graduation exercises of the Training School for Nurses were held at Convocation Hall, Tuesday evening, June 7th. There were forty nurses in the Graduating Class. The Rt. Rev. Bishop of Niagara addressed the graduating class.

Scholarships for post-graduate work were presented to: Misses Mary Clackwood and Kathleen Clearihue, post-graduate course, University of Toronto; Miss Katharine Scott, efficient work in the operating room; The Florence J. Pott's Scholarship presented by the Hospital Alumnae Association to Miss Reba Simpson, graduate, 1925; Highest standing in practical work, Miss Elizabeth Chamberlain; Highest standing in general proficiency, Miss Mabel Townsend; Highest standing in City of Toronto Medical Emergencies, Miss Anna Hulbert; For efficient bedside nursing, Miss Effie Borland.

After the graduating exercises the guests of the Class and invited guests returned to the residence for dancing and refreshments.

Miss Austin, Superintendent of Nurses, was the representative from Hospital for Sick Children to the Canadian Nurses Association Convention held at Saint John, N.B., in June.

Miss Marian Kennedy (1930), who has been in England this last year taking a post-graduate course, has returned and is now on the staff at Hospital for Sick Children.

Misses Francis (1930) and Gelling (1930) have joined the staff at Thistletown. Miss Boughton (1931), post-graduate from Montreal General Hospital, has joined the operating room staff. Mrs. Wm. Keith (Eleanor Newberry, 1925), who was married to Dr. Wm. Keith at St. Luke's Church, Chelsea, London, England, on April 4, 1932, has returned home. Miss S. A. Kinder was in town from Montreal for the Graduation dinner and presented the Florence J. Pott's scholarship the night of graduation.

WELLESLEY HOSPITAL, TORONTO: Miss Campian and Miss Lytle (1930) are taking a post-graduate course in obstetrics at the Royal Victoria Hospital, Montreal, P.Q. Miss Solomon and Miss Stanton (1931) have been abroad for two months. Miss Emma Maylor (1918), in charge of the Public

Health Department, Albuquerque, New Mexico, has been spending holidays in Forest and Toronto.

GENERAL HOSPITAL, TORONTO: Miss Naomi Piggott (1932) has accepted a position as assistant operating room supervisor at the Metropolitan General Hospital, Walkerville, Ont. Misses Helen Herbert, Rowena Hatch and Helen Russell have been on the Toronto General Hospital staff for the summer.

TORONTO WESTERN HOSPITAL: In response to a request to accept part payment of expenses and attend the General Meeting of the Canadian Nurses Association held at Saint John, New Brunswick, Miss Rahno Beamirh (1919), President of the Alumnae Association and Miss Maud Campbell (1931), Recording Secretary, represented the Alumnae.

NICHOLLS HOSPITAL, PETERBOROUGH: The Nicholls Hospital Alumnae held their annual picnic on June 15th at Miss Dickson's cottage, Kiwarth Park, Stoney Lake. A very pleasant afternoon was spent swimming and playing baseball.

DISTRICT 6

NICHOLLS HOSPITAL, PETERBOROUGH: The Nicholls Hospital Alumnae held their annual picnic on June 15th at Miss Dickson's cottage, Kiwarth Park, Stoney Lake. A very pleasant afternoon was spent swimming and playing baseball.

DISTRICT 9

NORTH BAY: Mrs. Edith Bagshaw and Miss Marguerite Hopper, representatives from the Provincial Department of Health, spent several weeks in North Bay making a survey and were guests of honour at the Graduate Nurses' Social Club at the May meeting. At that meeting, held at St. Joseph's Hospital, Miss K. MacKenzie, Chairman of District 9, gave a detailed report of the Registered Nurses Convention held in Ottawa Easter week.

The June and closing social for the year of the North Bay Nurses' Social Club was held at the summer home of Mrs. A. Adams, Lake Nipissing. Chicken dinner was served to about forty guests. Cards and bathing made a pleasant evening for all.

QUEBEC

SHERBROOKE HOSPITAL: Miss Verna K. Beane, assistant superintendent, has returned to resume her duties after a month's vacation. Miss Louise A. Douglass has resigned her position as night supervisor and is leaving for her home in Stanley, N.B. Miss Marjorie Carr succeeds Miss Douglass. Miss M. Edyth McDowell, instructor, is spending her vacation at her home in Brandon, Man.

JEFFERY HALE'S HOSPITAL: Misses C. E. Armour, G. H. Weary and D. M. Anderson attended the C.N.A. meeting in Saint John. The graduating class was entertained at a dinner in May at the Chateau Frontenac by the Alumnae. The decorations were effectively carried out in the school colours of blue and gold. As a souvenir of the occasion each guest received a blue and gold butterfly. Miss MacKay, president, presided. Part of the

programme consisted of the following toasts: "The King," Miss Irmie; "Our Alma Mater," Mrs. M. Craig; "Our Guests," Mrs. S. Barrow (Response, Miss O. Smollett); "Our Absent Friends," Miss D. Jackson (responded to by Miss Fischer). The absent friends sent several telegrams and messages of good cheer. The class prophecy, read by Miss E. Case, was greatly appreciated by all present. Miss Fischer acted as convener in her usual capable way.

The sympathy of the Alumnae members is extended to the parents and sister of Miss Cecile Caron (1917), whose death occurred on July 14, 1932, after a brief illness. Miss Caron had been on the nursing staff, Jeffery Hale's Hospital, for some time previous to her death.

SASKATCHEWAN

The Saskatchewan Registered Nurses' Association has awarded three scholarships for University courses since 1929. This year's award was made to Miss Kathleen Rowley, of Craik, Saskatchewan, who will enter McGill University this fall for the post-graduate course in Teaching and Administration in Schools of Nursing.

Application forms for the 1933 scholarship will be mailed to all members of the Association in January, and the award will be made at the annual meeting during Easter week. Miss E. Smith, Normal School, Moose Jaw, is the Convener of the Scholarship Committee.

C.A.M.N.S.

HAMILTON: Mrs. (Dr.) Cowan entertained the Hamilton Unit of Overseas Nurses at a delightful evening on July 13th at her home near Grimsby. There were seventeen nurses present, including Mrs. Cowan, who is a member of the Hamilton Unit.

VANCOUVER: On August 20th a delightful garden party for the members of the Overseas Nursing Sisters' Association was held at the residence of Mrs. Bradford Heyer. Badminton and clock golf were enjoyed during the afternoon by the guests, who were received by Mrs. Heyer, assisted by Miss Jane Johnson, president, and Miss Jean Matheson, matron of Shaughnessy Hospital. Tea was served on the wide lawns and, later, bridge was played in the evening.

SCHOOL FOR GRADUATE NURSES, MCGILL UNIVERSITY

At the C.N.A. General Meeting, memories of which will not soon be forgotten, a hastily arranged lunch of the Alumnae took place, with a very splendid representation in attendance.

The members were fortunate in having two of the honorary members present: Miss Hersey of the Royal Victoria Hospital, Montreal, and Miss Grace Failrey of the Vancouver General Hospital, Vancouver; also Mrs. I. Manson Prince, Assistant Director, School for Graduate Nurses, McGill University.

Members of the Alumnae present were: Miss Jean Wilson, Executive Secretary, C.N.A., Winnipeg; Miss E. F. Upton,

Executive Secretary, A.R.N.P.Q., Montreal; Miss M. K. Holt, Lady Superintendent, The Montreal General Hospital, Montreal; Miss Anne Slattery, Public Health Department, Windsor, N.S.; Miss Beamish, Assistant Superintendent of Nurses, Toronto Western Hospital, Toronto; Miss Grace Bell, Assistant Superintendent of Nurses, Grace Hospital, Toronto; Miss Mary Bliss, Perth, Ont.; Miss Aileen Pringle, Instructor, St. Luke's Hospital, Marquette, Mich.; Miss Orr, Superintendent, Shriner's Hospital, Montreal; Miss Fidler, Director of Nursing, Psychiatric Hospital, Toronto; Miss Acland, Assistant Superintendent, Strathcona Hospital, Ottawa; Miss Allen, Victorian Order of Nurses, Toronto; Miss F. A. George, Lady Superintendent, The Woman's General Hospital, Westmount; Miss Victoria Winslow, Superintendent, The Children's Hospital, Halifax; Miss Myrtle MacMillan, Superintendent, General Hospital, Glace Bay, N.S.; Miss Marion Boa, Superintendent, Aberdeen Hospital, New Glasgow; Miss

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BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BAUMAN—On June 29th, 1932, at Kitchener, to Mr. and Mrs. L. Bauman (Beatrice Hunstein, Kitchener and Waterloo Hospital, 1927), a son.

BRADY—In August, 1932, at Parry Sound, Ont., to Dr. and Mrs. Brady (Phyllis Mosley, Toronto General Hospital, 1927), a son.

COLE—On August 2nd, 1932, at Brantford, to Mr. and Mrs. J. M. Cole (Mary Slee, Brantford General Hospital, 1930), a daughter.

EASTON—On August 5, 1932, at Toronto, Ont., to Dr. and Mrs. Norman Easton, a son.

HEWITT—On August 18, 1932, at Saint John, N.B., to Dr. and Mrs. S. R. D. Hewitt (Edna Dow, Toronto General Hospital, 1911), a son—David Garry Ross.

LEHMAN—On April 6, 1932, to Mr. and Mrs. Bert Lehman (Muriel Griffin, North Bay Civic Hospital), a son.

LYON—On August 19, 1932, to Mr. and Mrs. B. Lyon (Ruth Edney, Jeffery Hale's Hospital, Quebec, 1931), a son.

McCULLY—On August 18, 1932, at Toronto, Ont., to Mr. and Mrs. Thomas McCully (Muriel Burrell, Toronto General Hospital, 1931), a son.

McDOUGHALL—On August 18, 1932, at Toronto, Ont., to Mr. and Mrs. McDoughall (Sadie McDonald, Toronto General Hospital, 1923), a son.

NEWMAN — On December 24, 1931, to Mr. and Mrs. Carl Newman (Anita Parks, Hamilton General Hospital), a son—Wallace Carl

OGG—On August 19, 1932, at Guelph, Ont., to Mr. and Mrs. Charles Ogg (Annie Cross, Guelph General Hospital, 1921), a daughter.

PRITCHARD—On August 23, 1932, at Toronto, Ont., to Mr. and Mrs. Harry Pritchard (Leila Ham, Toronto General Hospital, 1921), a daughter.

RIDDELL—On August 12, 1932, at Brantford, Ont., to Mr. and Mrs. George R. Riddell (Beatty Hill, Brantford General Hospital, 1926), a son.

SEARS—On July 21, 1932, at Lamont, Alta., to Mr. and Mrs. Robert Shears (Alma Ross, Lamont General Hospital, 1927), a daughter—Louie Maxine.

SHANNETTE—On August 15, 1932, to Dr. and Mrs. A. Shannette (M. Meikle, Wellesley Hospital, Toronto, 1926), a son.

TAYLOR—On April 30, 1932, at Winnipeg, Man., to Dr. and Mrs. Jack Taylor (Molly Osborne, Winnipeg General Hospital, 1927), a daughter.

TAYLOR—On June 26, 1932, at Sherbrooke, Que., to Mr. and Mrs. Ross Taylor (Maude Pearson, Sherbrooke Hospital, 1926), a daughter.

WAMERSLEY — On May 18, 1932, at Winnipeg, Man., to Mr. and Mrs. T. E. Wamersley (Mary Floyd, Winnipeg General Hospital, 1927), a daughter.

WAUGH—On July 23rd, 1932, at Winnipeg, Man., to Mr. and Mrs. H. E. Waugh (Marjorie Ross, Winnipeg General Hospital, 1929), a daughter.

WHITE—On August 27, 1932, at Toronto, Ont., to Mr. and Mrs. White (Hilda Aldous, Toronto General Hospital, 1927), a daughter.

MARRIAGES

BARR—CAMPBELL—On August 27, 1932, at Lanark, Ont., Flora Campbell (Toronto General Hospital, 1929), to Lindsay Barr.

BLANCHET—FLEMING — On April 5, 1932, at North Bay, Ont., Mrs. Mabel Fleming (Port Arthur General Hospital) to John Blanchet, of North Bay.

BOLDUC—NOONAN—On August 1, 1932, at Quebec, Margaret Noonan (Jeffery Hole's Hospital, Quebec, 1929), to Ernest Bolduc, formerly of Lewiston, Me.

CARTHES—HARVEY—On July 30, 1932, at Deseronto, Ont., Helen Harvey (Toronto Western Hospital, 1921), to William Thomas Carthes.

COOK—HOFFMAN — On June 17, 1932, at Toronto, Mabel Christina Hoffman (Toronto Western Hospital, 1930), to James Thomas Cook, B.A.

EDWARDS—MILLING — On August 6, 1932, at London, Ont., Mildred L. Milling (Toronto Western Hospital, 1928), to A. Earl Edwards, of Toronto, Ont.

GRAY—ADAMS — On July 20, 1932, at Matapedia, Que., Louisa M. Adams (Jeffery Hale's Hospital, Quebec, 1928), to Peter Gray, formerly of Scotland.

GREENLEY—PAIGE—On June 25, 1932, at Greenley, Que., Pearl M. Paige (Sherbrooke Hospital, 1930), to Irwin Greenley, of Greenley, Que.

HAGEY—BARBER—On August 25, 1932, at Port Elgin, Ont., Frances Barber (Toronto General Hospital, 1930), to C. N. Hagey.

HARKNESS—HANNAFORD — On July 30, 1932, at Sundridge, Ont., Frances Lillian Hannaford (Toronto General Hospital, 1923), to James Lindsay Harkness. Mr. and Mrs. Harkness will reside at Ansonville, Ont.

JAMESON—ROE — On June 8, 1932, at Bolton, Ont., Dorothy Viola Roe (Toronto Western Hospital, 1929), to Thomas H. Jameson.

KELLAWAY—PHILPOTT—On May 25, 1932, at Chicago, Ill., Leah Philpott (Hamilton General Hospital, 1924), to Gilbert Walter Kellaway, of Galesburg, Ill.

KILPATRICK—POPLESTONE—On July 9, 1932, at Blyth, Ont., Jeannette Poplestone (Guelph General Hospital, 1930), to Dr. Carman Douglas Kilpatrick, of Blyth, Ont.

LESURF—PARSONS—In April, 1932, at Peterborough, Ont., Frances Parsons (Nicholls Hospital, Peterborough, 1930), to William Lesurf, of Peterborough, Ont.

McCREA—COLES — On August 3, 1932, Maude Elizabeth Coles (Sherbrooke Hospital, 1929), to Robert P. A. McCrea, of Sherbrooke, Que.

READY—STEVENS—In July, 1932, at St. Mary's, Ont., Mary Stevens (Toronto General Hospital, 1929), to James Ready, of Quebec.

RUDOLF—WISEMAN — On August 20, 1932, at Toronto, Ont., Anna Wiseman (Toronto General Hospital, 1930), to Robert Rudolf.

SMITH—DURELL—In May, 1932, at North Bay, Ont., Jessie Durrell (North Bay Civic Hospital) to Reuben Smith. Mr. and Mrs. Smith will reside at Shawville, Que.

SMITH—JAMES — On June 17, 1932, Katie E. James (Hazelton Hospital, Hazelton, B.C., 1928), to Wallace J. Smith, of Bassano, Alta.

VAREY—STEPHENSON — On February 14th, 1931, at Toronto, Ont., Beatrice Eileen Stephenson to Dr. D. H. Varey, of Brantford, Ont.

WOLFF—BRADLEY—On June 25, 1932, at Quebec, Que., Nellie Winnifred Bradley (Jeffery Hale's Hospital, Quebec, 1928), to Grant Roy Wolff, of Monument, Que.

DEATHS

BOULTON — On June 12, 1932, at Winnipeg, Mrs. J. A. Boulton (Norah O'Grady, Winnipeg General Hospital, 1925), of Denman Island, B.C.

CARON — On July 14, 1932, at Quebec, Que., Cecile Caron (Jeffery Hale's Hospital, 1917), after a short illness.

COLTON—On July 1, 1932, at Ottawa, Ont., Mrs. George Colton (Elizabeth Le Roy, St. Luke's Hospital, New York City, 1912).

DESTMAN—In June, 1932, at London, Ont., Ida Destman (Toronto General Hospital, 1920).

DEVERALL—On August 30, 1932, at Orillia, Ont., Capt. E. Victor Deverall, R.E., beloved husband of Dora Squires (Toronto Western Hospital, 1918).

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An Analysis of the Cost of Nursing Education^{*}

Introduced by JEAN I. GUNN, Superintendent, School for Nurses, Toronto General Hospital, Toronto, and Nurse Member of the Joint Study Committee, Nursing Education in Canada.

The fact that this session of this general meeting of the Canadian Nurses Association is to be entirely devoted to the discussion of the cost of nursing education immediately brings to one's mind two thoughts: first, the programme as planned clearly indicates the importance of this subject in the future development of nursing education in Canada; and, second, the fact that this economic question, which is at the base of all branches of education, has not yet been satisfactorily dealt with, although some of the schools of nursing in Canada have already passed the fiftieth anniversary of their existence.

To really understand why such a delay in facing facts and placing nursing education on the same basis as all other branches of education in this country, it is necessary to go back to the early days of nursing and to review briefly its developments. The early leadership in nursing in Canada was largely inspirational and religious. The settlement by the French in the sixteenth and early seventeenth centuries brought with it the religious influence, and from that time up until the era of commercial and industrial expansion in the nineteenth century, and the specialisation of the twentieth century, the history and development of nursing is closely interwoven with the development of Canada as a whole. In the early days when settlements were coming into existence and hospitals being organised to care for the sick, the emphasis

was placed on the actual bedside nursing care of the patient in each individual hospital, and little or no thought was given to the preparation of the personnel to whom this care was assigned. Then came the introduction of a definite plan for educating nurses, the first Canadian school being opened in the St. Catharines General Hospital in Ontario in 1873. Other hospitals soon organised nursing schools, as it was very apparent that under this plan the nursing service in the hospital could be more efficiently done. From 1873, when the first school was organised, up until the present time there has been no control of any kind in the organisation and administration of schools of nursing. Hospitals have organised and conducted schools regardless of their facilities for this important educational undertaking. Most hospitals are considered, both by their trustee boards and by the community, to be business organisations rendering a public service in the care of the sick. The fact that they are also the educational institutions to which are entrusted the education of the nurse is seldom considered from a serious educational standpoint. The student nurse became a necessary cog in the machine which had been set going, and the chief interest in her from the standpoint of the hospital was only for the period that the cog remained in action in that individual hospital.

Gradually factors outside the hospital began to demand changes in the education of the nurse if she was to meet the ever-increasing demands for many and varied types of service. The rapid development in the field of

(*Papers read at a General Session, Canadian Nurses Association General Meeting, June 22, 1932.)

scientific medicine, the phenomenal advance of surgery, the organisation of public health and social welfare activities, have brought with them urgent demands for efficient service from the nurse in all these extremely complex and vital undertakings. The modern hospital has become, whether willingly or unwillingly, the laboratory for the practice of modern medicine and surgery, the carrying out of which requires a very specially trained personnel. In the early days, when the student nurse's time was devoted to the bedside care of the patient, and when her education was restricted to preparing her for this service, the hospital may have been justified in undertaking this so-called educational project. But, today, the conditions are entirely different. Unfortunately, the actual time devoted to the bedside nursing care of the patient is becoming rapidly less and less, while the time devoted to the co-operation with the medical and surgical staffs in the many branches of research undertaken, in the carrying out of special treatments, in the assistance given to surgical procedures, is becoming greater and greater. If the nursing staff of the hospital had only the responsibility of the actual bedside nursing of the patients, the personnel could be very materially reduced. This is an economic factor that is seldom realised or acknowledged. The world has gradually, or one may say rapidly, reached an age of scientific specialisation, and this development applies to every profession and every type of work. The nursing profession is no exception. A sentence in the Survey Report stresses this fact: "As a modern specialist in medicine differs from the nineteenth century family doctor, or as a pastor of a wealthy congregation differs from the itinerant missionary on the remote frontiers of civilisation, in somewhat similar fashion may it be said that the best type of present-day nurse differs from the illustrious sisterhood immortalised in the early annals of Canadian history."

It is obvious that the nursing profession cannot remain static while evolutionary forces affect all other workers in the community. Nursing has been too long in the transition stage between the old and the new, looking into the past and regretting the fact that sound educational foundations were not laid, yet hesitating to pull down the old structure and rebuild on a basis that will serve at least as a starting point for the future development of nursing education and nursing service. It was the endeavour to find that starting point that led to the Survey of Nursing Education in Canada. Definite knowledge of present conditions was essential, giving facts, not opinions, of many disputed questions, such as: the efficiency of the nursing service now being rendered; the extent to which the nursing needs in the community were being met; the degree to which the nurse's education fitted her for the service she is called upon to give in the many and varied fields of nursing; the educational and other qualifications with which the prospective nurse entered for training, and the economic conditions of the nurses. Many others ought to be added, but these are sufficient to indicate the need of definite information before any intelligent planning for the future can be done. It is essential to understand the nursing situation from all standpoints before the proper solution can be decided.

We are all creatures of habit, and this extends to hospital boards of trustees. They might be said to have the "school for nurses" habit. The school for nurses has been a part of the hospital since its establishment and is more or less taken for granted. All fields of hospital service have been subjected to careful study from the economic standpoint, the one exception being the cost of educating the student nurse. Hospital boards of trustees have also carefully outlined the scope of hospital service and have not undertaken activities that did not logically belong to them. Why, then,

have they not given the same logical consideration to the question of nursing education and nursing service?

In the discussion of this subject we must always bear in mind the fact that we have in Canada many hospitals in which conditions have not materially changed since their organization. These hospitals are contributing practically nothing to nursing education and, therefore, cannot be considered in the discussion of cost analysis. Care must be taken in not permitting these institutions to confuse the facts, either in our own minds or in the mind of the public as a whole. Each hospital of this type will claim to be conducting a school for nurses, but in reality they are functioning in the same manner as in the early days of nurse training, giving their students sufficient practical instruction to enable them to carry out the nursing service of that individual hospital. The board of trustees of such a hospital has no sense of responsibility, and in reality gives little thought to the fact that the hospital is posing as an educational institution in which the nurse is expected to receive the necessary preparation to fit her for nursing service in its broadest sense. In this connection the Survey states, "If the student nurse is being exploited in the interests of the hospital rather than given an adequate education, it becomes the duty of the state, in the discharge of its obligations to the community and to the student, to stop such exploitation."

The hospitals that must be included are those which are honestly endeavouring to give the student nurse an adequate education to fit her for her profession. These hospitals will have to approach the subject with an open mind and allow the facts to speak for themselves. One fundamental consideration is whether the education of the student nurse under present-day conditions is really a responsibility that the hospital should be expected to undertake unaided, or be willing to undertake unaided. In the

early days, when the education of the student nurse was planned only to make her a useful member of the nursing personnel of the individual hospital from a practical standpoint, and when her duties were only those of the bedside nursing of the patient, the answer to this question might be easier to establish. At that period of development, when her entire time was given to the patient, the answer to this question might well be different from the answer to the same question under present-day conditions.

What are the present-day conditions? What is the objective of nursing education today? To what extent should the hospital, through the school of nursing, attempt to reach that objective? Should the hospital assume the financial responsibility of educating nurses in preparation for fields of work other than the actual nursing care of the hospital patients? All these questions must be studied and the logical answers found. To decide where the responsibility of the hospital begins and ends is not easy, as it is impossible to carry on the work of treating and caring for patients without a nursing personnel whose scientific training makes possible the carrying out of the demands made by physician and surgeon for this very special knowledge, co-operation and efficient service. The nurse is often referred to as the handmaiden of the doctor. In all branches of nursing: hospital, private duty, and public health, she is being called upon to a greater and greater degree to be much more than a handmaiden. She is rapidly taking on responsibility that in former years belonged to the doctor. As the work of the doctor, whether he be physician or surgeon, became more specialised and complex, he, of necessity, had to free himself from old duties in order to have time for the newer developments in his work. In observing the evolution of hospital nursing over a period of years it is quite easy to follow the gradual passing on of increasing responsibility to the nursing staff.

These new duties cannot be undertaken without training and definite knowledge. Nursing education must keep abreast of medical practice and medical education. The hospital might well study the education of the nurse from this standpoint. Is it the sole responsibility of the hospital to make possible the application and the testing of the newly established facts of medical research? The hospital is the logical laboratory for the practice of medicine, but should the hospital assume all the cost of this development or should the financial outlay be shared by the governmental bodies? The special interest of this Association is naturally that of educating the nurse, so that she may be fitted in every way to meet the demands for efficient service from all the fields of medical practice.

How should this education be financed? In order to answer that question it will be necessary to go much further and to actually know what the nurse's education is costing the hospital, or would cost if properly carried out; what her maintenance, illness, etc., is costing, and what her services are worth to the hospital, in order to place this on the credit side of this analysis. It would also seem logical to question to what extent the nursing service of the hospital benefits from the educational programme. Is the hospital spending time and money preparing the nurse for services not included in the individual institution? This is found to be done in all hospitals whose students are sent for affiliated courses to other hospitals in order to complete the required training in branches of nursing not found in the home school. Affiliation for student nurses is a costly undertaking and should be carefully shown on the debit side of this analysis. The comparative value of the services of the graduate nurse and the student nurse from an economic standpoint should be studied and the findings should have a direct influence on the policy adopted for future nursing service.

In considering the question of nursing education it would be advisable to make a careful study of the methods adopted for the carrying on of other branches of education. *The time has come when nursing education must be considered as an important part of the educational system of the country. In this consideration we should have established governmental control as to what that education shall be and where it shall be given.* It was thought by the nursing profession that the Registration of Nurses Acts in the different provinces would have brought about better conditions in nursing education. To some extent conditions have improved in many schools for nurses, and in some cases hospitals, unable to give an adequate training, have discontinued the school of nursing and established a graduate nurse service. I do not wish in any way to fail to give credit where credit is due, but it should be remembered and stressed that the legislation concerning nursing education now in force in the different provinces is permissive legislation. There is really no definite control established. Any hospital may conduct a school for nurses, regardless of educational facilities and clinical experience offered. If, however, the hospital wishes to have its graduates eligible for registration under the Registration of Nurses Act, certain standards must be attained. It would seem that in any educational undertaking the first consideration should be the institution in which that education is to be given. That important matter will have to be settled before any progress can be made as to the apportioning of the cost of nursing education. It must also be borne in mind that schools for nurses are not filling only a local need. They serve the community in which they are located, the province, and Canada as a whole in the same way as other educational institutions, colleges and universities fill a national need and are truly national in their scope. If the issue is to be squarely faced and constructive planning made possible,

the legislation concerning schools of nursing should cease to be of the permissive type and become compulsory, so that no hospital would be permitted to conduct a school for nurses unless the standard educational requirements were satisfactorily met. The Survey makes the following statement: "No institution should be permitted inefficiently to conduct an important enterprise, vitally concerning the public interest, simply because the process is cheap and economically advantageous to the institution concerned. The interest of the public at large should transcend private and local considerations."

Under a system of definite governmental control, it would be possible to develop in the schools for nurses a standard system of cost accounting. The Survey emphasizes the difficulties encountered in endeavouring to arrive at any accurate estimate of the cost of nursing education and nursing service. The facts are lost in a mass of figures of hospital expenditures, and the lack of uniformity in the existing systems of cost accounting in hospitals makes it practically impossible to really ascertain the information required. Even before this standardisation of method can be effected, the schools for nurses could and should study the nursing costs by preparing a budget for the operation of the school. In collecting the information even for the original budget, an important advance will be made toward establishing the practice and the necessity of studying nursing costs and nursing service. The average hospital can now supply accurate information as to the cost of any commodity used in the hospital. The time has come when this practice should be extended to the nursing service.

The Survey Report states that the net cost of educating a student nurse is the difference between the monetary value of her services to the hospital and the total cost of her education. It also states that the adequate education of the nurse, as of

the teacher, is a national enterprise entailing national obligations which should not be saddled on any local community or hospital. If we survey, even superficially, the fields of nursing in which nurses are working, we find them employed by governments, municipal and provincial, through health departments, education departments, hospitals and industries. If the health activities of the government which are operated to promote the welfare of the people of our country are largely carried on through the nursing service, should not that government take some responsibility for controlling and financing the education of the nurse to whom this health service is entrusted?

It is very logical to come to the conclusion that the schools of nursing should receive government subsidy, but it is not so easy to induce the government to arrive at the same logical conclusion. We will have to prove our case, and in order to do so there are certain inevitable preliminary steps. The first step is to have the nurses of Canada learn to work together and to accept guidance and advice from those whose responsibility it is to give such guidance and advice. In each province a carefully planned campaign will be launched and should be supported by every nurse in the province. Until we as nurses learn to work together there will be little progress made. We are in danger of scattering our energies and in the end accomplishing little. In this campaign we should cease dividing into different groups, private duty in one, institutional nurses in another, and the public health in still another group, each group advancing its own interests and, in a very short-sighted way, overlooking the fact that what affects one group affects all. Nor can a few nurses in each province assume this great responsibility. Unless we are united, each nurse taking her full responsibility, the campaign for better educational opportunities for nursing has failed before it is launched.

The second step is for each nurse to study the Survey Report and to know the facts, the arguments and the recommendations offered. Already many hospital nursing staffs, alumnae associations, and other nursing associations have organised study groups. This plan of organised study is working out very satisfactorily since it gives an opportunity for informal discussion. I would like to emphasize here again the importance of such groups studying the Survey Report as a whole and not to select only the part relating to a particular field of work. Each nurse should be well informed for her own information, and also to enable her to discuss intelligently the findings of the Survey, particularly with members of the laity with whom she comes in contact.

The third step is to interest the public in the facts presented in the Report and in the solutions suggested. An uninformed public is an uninterested public. Each nurse, in whatever field of work she is employed, has some contact with the community and can do a great deal toward interesting individuals. In all probability, each province will have a definitely planned publicity campaign, but this can never replace the efforts of the individual nurse.

The fourth step is to make a definite effort to inform the doctors of the existing conditions and to solicit their support. In any constructive plan the relationship of the nursing and medical professions must be carefully considered. This will, of course, be done officially through the organised professional groups, but we need in addition the support and sympathetic understanding of the individual physician.

I have left the most important suggestion until the last, as I wish to emphasize it more than any of the others. Our chief objective is to place nursing education on a proper basis, both from an educational and financial standpoint. This cannot be accomplished except through the co-opera-

tion of the boards of trustees in our Canadian hospitals. We can submit the facts for their consideration, present our recommendations for future development and necessary changes, but the definite action will depend on the decision of the board of trustees. That decision will depend largely on two factors: their approval or non-approval of the proposed programme, and their ability to undertake such a programme from a financial standpoint. In the first, that of securing the approval of the boards of trustees, the nursing profession will have to prove its case; in the second, we meet a situation with which we are all familiar, that of accepting the old ruling that nursing development must be curtailed through lack of funds in the hospital treasury. Ever since the beginning of nursing education the cost has always been thought of in connection with the hospital budget. There has been no separation of nursing education and nursing service. Our facts should be so presented that the boards of trustees will begin to question and to study the part the hospital should logically undertake in the education of the nurse and to what degree the financing of that education should be borne by the hospital. In other words, they may overcome that habit of long standing, the "school for nurses" habit, and in so doing give valuable assistance in placing nursing education where it belongs, on the same basis as all other branches of professional education.

In closing this introduction to the papers that follow in this session, I would like to emphasize and to put into words the feeling that has been slowly growing and gradually taking form in the minds of most of the nurses in Canada. The very fact that the Survey of Nursing Education, which we are discussing at this meeting, has been made and to a large extent financed by the nurses of Canada is unquestionable proof that this feeling exists all the way across the Dominion, from coast to coast. What is this feeling to which I refer? It is

the realisation on the part of all serious-minded nurses that the time has come when nursing education must receive the same consideration and assistance as is now so generously given to the educational programme of all other professions, many of which do not relate in such a vital manner to the welfare of the nation.

The thought I wish to leave with you is the fact that we, as nurses, have a right to be heard. Our problem is a national one, and we must provide the leadership in its solution.

We cannot approach it in an apologetic manner and be assured of any success. We have been too passive and too prone to accept decisions not in the best interest of nursing education. All through the years, when nursing has gradually reached the chaotic state in which we find it today, we have accepted compromises, the benefit of which would have to be placed in all honesty to the advantage of the hospital. Let us unite in an effort to have some of the compromises on the credit side of nursing.

The Cost of the Student Nurse to the Hospital

By E. MURIEL McKEE, Superintendent, Brantford General Hospital, Brantford, Ont.

The purpose of this brief discourse is to endeavour to point out the many circumstances and conditions which affect the cost of the student nurse to the hospital, rather than to endeavour to establish definite items of cost. The Survey Report will be quoted frequently as many of the facts and findings contained therein are used as a basis for this discussion.

To discuss costs without consideration of values is futile. A request for the cost of any article is immediately met by a request for specifications as to quality required, inasmuch as costs are determined by certain definite factors: the cost of the raw material of an acceptable quality, together with the cost of properly producing the finished article, will give us the true cost. So with the cost of the student nurse, we must consider the qualities we require her to possess and the cost to the hospital of her education and maintenance. The Survey Report reveals the fact that estimates as to the cost of the student nurse to the hospital vary widely—scaling from statements to the effect that she is not a cost to the hospital but, on the contrary, an economic asset, to statements that she is more costly than the graduate nurse. Obviously there must be reasons for the wide variation of estimates.

Qualifications

The main qualities to consider in the student nurse are her intelligence, her health and her social and cultural background. Let us consider the relation of these qualities to cost.

Intelligence: The argument that the student nurse of low intelligence will cost more to educate than the student nurse of high intelligence is offset by the fact that the student of high intelligence will demand more education and better maintenance. The Survey finds: (a) That the larger the school, the higher the median intelligence quotient of the students (p. 202); (b) that the larger schools demand higher educational standards (p. 203); (c) that the larger schools provide more qualified instructors and devote more time to instruction than the smaller schools; (d) that the cost per student in the larger schools is higher than in the smaller ones.

A study of 33 hospitals with schools of nursing is illustrated in the accompanying chart, which contains data compiled from the Survey Report.

The costs, as indicated on the chart, B and C, have been estimated as follows: They are based on the value of the student nurse to the hospital as compared with the graduate nurse. One hundred and five superinten-

dents appraised the value of 1,739 students (p. 215). According to this rating, the average student nurse is about 55.5% as valuable to the hospital as the graduate nurse. Eliminating decimals and fractions, this means that 200 student nurses are the equivalent in value to the hospital of 111 graduate nurses.

The value of the graduate nurse to the hospital is arrived at by finding the amount of her remuneration from the hospital. The average gross income of the graduate nurse in hospital is \$1,385.00 per year (including allowance for board, lodging and laundry while on duty). This data was obtained from 115 superintendents of nurses. A careful accounting (Form O in the Report, p. 458), based upon reports from the thirty-three hospitals (Chart D) shows that the net cost—the difference between the monetary value of the nurse to the hospital and the total cost of her education—differs in the three groups. That in Group 1 it costs \$79.00 per year per student more to staff with students than with graduate staff; in Group 2, \$108.00 more, and Group 3, \$112.00 more. The figures in (c) have been computed as follows: One hundred and eleven (111) two hundredths (200ths) of \$1,385.00 equals \$769.00, the value of each student to the hospital.

Taking Group 1—\$769.00, plus \$79.00 (which is the loss to the hospital per year for each student), equals \$848.00, the actual cost per student per year. Group 2—\$769.00, plus \$108.00, total \$877.00; and in Group 3, \$769, plus \$112.00, equals \$881.00.

The Survey reports that 2,280 students in 109 schools were given the intelligence quotient test (an I.Q. rating 100 indicates average ability or an average degree of brightness). The result of the tests was a discovery that 55% of the students were of a rating of less than 100 and that the average I.Q. for the whole group was 98.3. Are the 55% of students with an I.Q. of less than 100 the students we hear of as the economic assets to

the hospitals? Quoting from the Report: "One conclusion is valid: these so-called students in the making were retained in spite of and not because of their intellectual calibre."

Health and Costs: While the Report shows that 92.8% of students accepted into nursing schools are required to have a physical examination prior to admission, less than 60% provide physical examination in the preliminary term, and only 18.6% in the first year, 15½% in the second year, and 6.9% in the third year (p. 175). It is logical to surmise that the student nurse in the school which provides thorough health examinations at regular periods during training, and further, attempts to correct physical defects found at time of examination, will be more costly to the hospital than the student in the school where these important considerations are neglected.

Social and Cultural Qualities and Costs: It is a foregone conclusion that students with good social and cultural backgrounds will expect to find in the nursing school an atmosphere compatible with former surroundings.

Having discussed the qualities of the student nurses and their relation to costs, we now proceed to study the nursing school. Here we have two definite factors determining cost (a) education, (b) maintenance. Much stress has been laid upon the size of the hospital in relation to the nursing school. It would seem better to take, as a basis for discussion, those fundamental requirements essential to the efficient preparation of the student for her professional career. While Canadian nurses as an association have not as yet set an "approved" nursing school standard, yet there are definite essentials recognised as absolute requirements in the efficient training of the student nurse. If these requirements are adhered to, the student nurse as an economic asset to the hospital will soon disappear, and no doubt many nursing schools, large and small, will discontinue.

Education and Costs

Clinical Education: Sufficient clinical material to insure a well-balanced education in all the major branches of nursing is the first essential. Where this material is not available and affiliations are required, the cost must increase, e.g., because of the loss of the service of the student while she

is away from the hospital, a larger number of students or added graduate staff will be required. Repetition of lecture courses and other educational work, lost by the student while away from the school, increase the load to the teaching staff. Then, too, there are travelling expenses and other incidentals.

CHART A

	Schools	Beds	Total	STUDENTS	
				Average per school	
Group 1	9	Less than 50	102	11.3	No full-time instructors, very little teaching equipment, practically no library facilities (p. 462).
Group 2	15	50-75	349	23.3	Seven out of 15 schools had instructors, 35% more time devoted to instruction than in Group 1 (p. 464).
Group 3	9	75 and over	454	50.4	Six out of 9 schools had instructors; 50% more time devoted to instruction than in Group 2 (p. 464).

CHART B.DECREASE IN COST TO HOSPITAL AS A RESULT OF
STAFFING WITH GRADUATE NURSES

Group 1	\$ 79.00
Group 2	108.00
Group 3	112.00

CHART C.

PRESENT COST

Group 1	\$848.00 per student nurse.
Group 2	877.00 per student nurse.
Group 3	881.00 per student nurse.
General Average	869.00, or about \$2.40 per day.

Value of student nurse to hospital as compared with graduate, $\frac{111}{200}$ of value.

Average income of graduate nurse, \$1,385.00 (p. 107).

$\frac{111}{200}$ of \$1,385.00 equals \$769.00 (1) plus \$ 79.00.

Therefore according to Group Classification

(2) plus \$108.00.
(3) plus \$112.00.

CHART D.

EFFECT ON COST OF ADEQUATE NURSE EDUCATION

Group 1	\$1,113.00
Group 2	1,027.00
Group 3	971.00

General Average, \$1,037.00—\$2.84 per day, or \$167.00 per year.

NOTE: Group 1, with all facilities, would still be lacking in clinical material.

**STUDY OF THIRTY-THREE HOSPITALS WITH SCHOOLS OF NURSING—
CHART PREPARED FROM SURVEY REPORT.**

Hospital Equipment: It is reasonable to assume that the cost of the student nurse to the hospital will be affected by the quality and quantity of the equipment of the hospital. It is most important to the education of the student that the hospital shall have adequate equipment to allow her to apply in her daily practice the exact procedures she has learned in the classroom.

Nursing School Staff and Costs: It is generally admitted that an adequate staff is a very important factor in the education of the nurse and has a very great influence on her cost. The minimum requirements are: superintendent of nurses, assistant superintendent of nurses, night supervisor, full-time, fully-qualified instructors in sufficient ratio to the teaching requirements of the students,

operating room supervisor, obstetrical department supervisor, and other ward supervisors in sufficient number to properly supervise the nursing service as rendered by the students; and other hospital or school staff, e.g., graduate nurses, ward aides, etc., to insure each student sufficient time during the day for rest, recreation and study; adequate clerical staff for nursing school is necessary to insure efficient administration. A sufficient number of doctors capable or willing to teach is an absolute essential. (The Report suggests that the doctors should be paid for teaching.)

Teaching Facilities of the Nursing School and Costs: A proper teaching unit is essential, including lecture and demonstration rooms, together with adequate teaching equipment, e.g., models, lanterns, charts, etc. A reference library for quiet study is an essential too often neglected.

Other incidentals worth consideration in the estimation of the cost of education of the student are graduation exercises, travelling expenses of the personnel to conventions, conferences, etc., postage and stationery supplies as used in the training school office and the class rooms. Referring to Chart A: Do not the 102 students in the nine schools in Group 1 and the 349 students in Group 2 require the same quality of instruction as the students in Group 3? (Note: We are told that the schools in Group 1 provide very little teaching equipment and practically no library facilities.)

Maintenance and Costs

The quality of the maintenance provided for the student nurse is a very important item and seriously affects costs. The social and cultural aspect of the nursing school plays almost as large a part in the preparation of the nurse for her professional career as does the academic and clinical education. Too little attention is paid to this phase of nurse training. The nurses' residence should possess an environment which will not only

maintain in the student nurse those qualities which we required her to possess on admission, but which will further develop and add to these qualities so essential to her ultimate success. The residence should be furnished so as to provide physical and mental rest and recreation to the varied taste of the students. The planning of off-duty activities cannot be left to the fatigued students, but should be carefully planned by a competent person. The following are a few of the many things which affect maintenance costs: whether the student has a single room properly furnished, or whether she lives in a dormitory, the quality of the food and the type of food service provided, type of housekeeping and whether it is done by maids or by the student nurses, the weekly linen allowance, personal and house linen, type of care given in illness, and so on.

We have so far discussed costs as they were found by actual survey. Were all schools on a comparative basis of efficiency, giving adequate education and providing suitable maintenance, the cost of the student to the hospital would be something like this (pp. 467-468):

Group 1.....	\$1,113.00
Group 2.....	1,027.00
Group 3.....	971.00

Note: Group 1, with all the facilities provided, would still be lacking in clinical material.

We have had in the past too many random statements about nursing costs. No doubt many hospitals, where they do analyse the cost of the student nurse, would be surprised to find that the figures would be quite contrary to their expectations. We have in the Survey Report sufficient reliable data to convince us that nurse education is costly. In those hospitals where it is admitted that the student nurse is a financial asset, we are forced to conclude the nursing service is supplied at the sacrifice of nurse education.

The Comparative Cost of the Student and the Graduate Nurse

By GRACE M. FAIRLEY, Superintendent, School for Nurses, Vancouver General Hospital, Vancouver, B.C.

Because of the almost entire lack of dependable statistics, either of the cost analysis of a school of nursing or a budget for the school, it is a difficult thing to come to any decision as to the comparative cost of graduate service or student service.

One cannot even take two hospitals with the same average occupied beds as a premise for argument as, unless these two institutions give an identical service; that is, a service to the patients, including equipment, scientific research facilities (which, in the case of the one with a school of nursing means the student's practical field work, which would include classroom equipment, number and type of instructors), it would be impossible to state with any degree of dependability that one was more economically run than the other, unless one was satisfied beyond question that the nursing care was also identical.

One hardly opens any hospital journal these days without finding some comments on the subject of reduction of schools of nursing, but as one writer states, "the pressure of present economic conditions is the reason for this discussion." Many of

us have realised for years that we were graduating more nurses than could possibly be absorbed within the Dominion, and had our neighbours to the south closed their doors years ago as they have done now, we probably would have discussed this vital matter the last time we met in the Maritime Provinces—nearly twenty years ago—rather than now.

The only figures I can submit which would in any way answer this question are those taken from a small hospital of 60 beds, which ceased to have a school of nursing and from which I have received figures—fairly accurately kept—of the last six months that it had a school of nursing and the corresponding six months of the first year that it was manned with graduates. The service has always been good in this hospital, and it had (for its size) a well-trained, efficient teaching staff. The figures are taken from the government returns.

I have also worked out what it would cost to staff a unit in a general hospital with graduates and the same wing with students, which includes the percentages of charges against the school for maintenance, etc.

COMPARATIVE STATEMENT OF COSTS FOR SIX MONTHS, WITH AND WITHOUT SCHOOL OF NURSING—HOSPITAL OF 60 BEDS.

	Care of Patients	Housekeeping	Total Expenditures
September, 1930.....	\$1,200.00	\$1,202.19	\$3,898.83
1931.....	1,156.31	1,010.16	3,652.74
October, 1930.....	1,425.68	1,359.72	3,940.51
1931.....	1,210.82	1,359.72	3,610.56
November, 1930.....	1,332.73	1,425.31	4,160.38
1931.....	1,143.15	962.99	3,155.12
December, 1930.....	1,252.36	1,649.12	4,241.33
1931.....	1,162.49	1,157.37	3,547.74
January, 1931.....	1,679.40	1,176.52	4,092.24
1932.....	1,168.67	943.19	3,302.21
February, 1931.....	872.61	1,305.51	3,563.36
1932.....	1,415.06	1,152.31	3,789.98
Total expenditure - - - -			
1930-31.....			\$23,896.63
1931-32.....			21,057.95
Average per month for six months, 1930-31.....			3,982.77
1931-32.....			3,510.00
Days' treatment - - - -			
1930-31.....			6,416
1931-32.....			7,052
Per capita cost - - - -			
1930-31.....			3.72
1931-32.....			2.98

In the case of the small hospital, the personnel as a school was: five graduates, fifteen students, two maids.

When staffed by graduates: eleven graduates, three maids, half-time porter.

Sickness incidence among students for this period was 397 days and among graduates 50 days annually.

You will see the reduction in the per capita cost of graduate service over school is 74c.

As the change was made with the same superintendent, who was essentially an educationist, I am assured that her figures and facts are sound and that the service would not suffer. She made the change with an open mind.

It was a little more difficult to arrive at the figures of the wing of the large institution:

Without school: 21 graduates, 4 maids. Cost \$3.00 per capita per diem.

With school: 6 graduates, 17 students, 4 maids. Cost \$1.71 per capita per diem.

There was a definite financial saving of approximately \$9,887.85 per annum (\$1.29 per capita per diem).

For a detailed cost account of a graduate and student service, however, I would refer the members to the financial and most comprehensive statement published in the April issue of the American Hospital Association Bulletin—vol. vi, number 4.

It gives a complete study of the expenses of the school of nursing of the Massachusetts General Hospital made by the auditors and accountants, and also shows in marked detail the expenses that could be eliminated if the school was discontinued. With this available authentic information, which would be invaluable for any institution working out a cost system for their school, it does not seem wise to take up our time here with statistics, however important and valuable they may be.

To return to the question of results, there is no doubt that a graduate ser-

vice, well organised, does give better service to the patient. But as graduates must be trained and as no hospital of any size can rely on the product of any other hospital for its entire staff, it would appear that an appraisal of our needs should be made to see how many hospitals should have schools of nursing and how many students should be graduated.

In the summary made by the superintendent of the 60-bed hospital referred to, she states that besides the financial saving that:

1. There can be closer supervision of the smaller group of workers (that is, the graduate staff).

2. That the greater sense of responsibility, especially of hospital property, results in more economical use of all supplies, particularly patients' record forms, dressings, linen.

3. Less illness among graduate staff, with consequent reduction of relief staff and cost of care during illness.

4. A fluctuation of staff is possible with graduate personnel if or when there is a reduction of patients—keeping a minimum staff and increasing it with temporary staff when the need arises. The same applies to domestic staff.

In a small hospital when, as sometimes happens, there is a sudden lull, it is bad for the morale of the student group.

This superintendent adds that she must confess that they are giving a better service than when they had a school of nursing.

To sum up the findings of this discussion, which are based on fairly wide observation and sources of available information:

1. It is less expensive for a large hospital to have a school of nursing, even when the school is well equipped and manned by well-trained and sufficient personnel.

2. It is more expensive for a small hospital to have a school of nursing if the school has the necessary equipment and personnel.

The Budget System

By MABEL F. HERSEY, Superintendent, School for Nurses, Royal Victoria Hospital, Montreal, Que.

In the Report of the recent Survey of Nursing Education in Canada the Director recommends the budget system for schools of nursing. Up to date very few schools, if any, in Canada are administered on the budget plan.

Existing Situation

Schools for years have operated with student nurses giving service to the hospital in return for their education and maintenance, and it is necessary to make sure that this works out satisfactorily for both student and hospital.

In the opinion of the student nurse of today, her daily services to the hospital entitle her to the best education available, and the hospital's attitude is that it should not set aside from hospital funds money to pay for nursing education other than the amount necessary to care for sick patients. Therefore it seems that some plan should be worked out whereby the cost of nursing education is separated from nursing service.

Financing

The Survey Report recommends the state paying the net cost of educating the student nurse; that is, the difference between the total cost of her education and her monetary value to the hospital, but until the schools are put on a sound financial basis, with better organisation and a fair budget prepared giving to the school and hospital each their proper share of salaries and expenses incidental to one, or both, they cannot ask and expect to receive appropriations or endowments.

Another method of financing often suggested is for the hospital to pay the student for her services at a certain hourly rate, and in return expect her to pay for her tuition and maintenance; or, to have this sum for student services paid into the school of nursing budget, to be used solely to pay for the maintenance and education of the nurse.

Publicity

It is very important that the community should have definite knowledge of the cost of maintaining a nursing school, and what proportion of the hospital fund is not spent on the actual care of the patient. This is not really understood now except by those in possession of the facts. Nursing schools in preparing student nurses are making an enormous contribution to the health of the community, for which they are receiving, on the whole, little credit, and the hospital executives have been shortsighted in not giving the public more information as to the value of the hospital as an educational centre.

Today we are dealing with the question of whether the school of nursing needs, in the interests of nursing education, to be freed from hospital control. Hospitals have been satisfied to conduct these schools as long as they were assured the outlay for the education of the nurse would not exceed the returns in nursing service, but whatever financial returns are gained for the hospital by student nurses should be returned for the benefit of education.

The nursing needs of the patient and the educational needs of the nurse are one, and must remain so. There cannot be good nursing experience and instruction except in the presence of good nursing care.

This is a critical period in nursing education, but by working together, surveying the whole field in a broad way, and facing the facts honestly and fairly, we may hope to arrive at the needs of the nursing service; the work which the nurse is expected to do; the kind of preparation she needs; and the best way of preparing her.

The Need of a Budget

Whether it is desirable in all cases to develop budgets in schools of nursing is sometimes questioned, but every hospital should be in a position

to state what part of the expenses of the hospital as a whole should be charged to the nursing department.

Almost without exception nursing schools have no independent funds and no income of importance outside of the estimated earnings of the student nurses, and hospital and nursing accounts are so involved that it is almost impossible to separate them accurately.

Budget

Budgeting is a process of gradual development, and takes hold as a habit only when its benefits are understood by those whose activities are affected. The object of the budget is to obtain, in advance, a comprehensive idea of the estimated annual cost of operating the school. It enables the administration to make plans in advance for the year's financial obli-

COST OF MAINTENANCE AND EDUCATION OF THE NURSE IN TRAINING

"A"—Maintenance:

Fixed Charges:

(a) Interest on capital	\$33,500.00
(b) Allowance for depreciation, 1% per annum	6,700.00
	<hr/> \$ 40,200.00

Annual Budget of Current Expenses:

1. Repairs, replacements, etc.	\$ 1,609.00
2. Heating	1,395.00
3. Lighting	1,535.00
4. Fire insurance	560.00
5. Telephones	87.00
6. Linen supplies	1,209.00
7. Cleaners and cleaners' supplies	744.00
8. Laundry	2,028.00
9. Food	31,500.00
10. Allowance (students)	14,400.00
11. Illness (hospitalisation)	4,860.36
12. Supervision (housekeeper and maids, nurses' home).....	4,650.00
13. Maintenance of above	2,460.00
	<hr/> 67,037.36

Total cost of maintenance of 150 nurses for one year	\$107,237.36
Total cost of maintenance of one nurse for one year.....	714.91
Total cost of maintenance of one nurse for one year, eliminating fixed charges	446.91

"B"—Education:

1. Salaries of full-time instructors	\$	3,730.00
2. Percentage of Salaries:		
Superintendent of Nurses and	}	7,256.53
Assistant Superintendent of Nurses (½ of 4)		
Supervisors and Head Nurses (1.5 of 36)		
3. Classroom supplies		450.00
4. Postage, stationery and printing		250.00
5. Graduation expenses		300.00
6. Diplomas and pins		723.25
7. Calendars		143.00
8. Taxis		75.00

Total cost of education of 150 nurses for one year.....	\$ 12,927.78
Total cost of education of one nurse for one year	86.18

Summary

"A"—Cost of maintenance of 150 nurses	\$107,237.36
"B"—Cost of education of 150 nurses	12,927.78
	<hr/>
Total cost of 150 nurses for one year	\$120,165.14
Cost of maintaining and educating one nurse for one year.....	801.10
Cost of maintenance and education of one nurse for one year, eliminating fixed charges	533.10

gations and to curtail or expand as conditions may warrant. It serves as a comparison for present and future operations. It provides for flexibility of adjustment according to needs. It should enlist to the greatest possible extent the interest of executive subordinates in preparing estimates affecting the work.

The book-keeping methods of the hospital should be so arranged that monthly or periodical trial balances may be taken out and compared with the estimated figures of the budget.

Briefly, the operation of a budget system involves what items should make up the running expenses after allowing for any income received as endowment or from any other source which has been specifically pledged for the training school activities only.

As the first step in solving the problem of costs is the preparation of an annual budget, the following outline has been prepared showing, first, a budget of current expenses, and, second, the estimated cost of educating the student nurse for one year:

The following recommendations are presented for consideration:

1. That the Canadian Nurses Association communicate with the boards of trustees of all Canadian hospitals conducting training schools for nurses with the following suggestions:

(a) That the board of trustees study the Report of the Survey of Nursing Education in Canada, especially those sections dealing

with the education of the student nurse;

(b) That each hospital undertake a definite study of Nursing Costs within its own institution, with a view to estimating and comparing the cost of Nursing Education and Nursing Service;

(c) That the board of trustees co-operate in working out a uniform method of cost accounting for use in all hospitals conducting training schools for nurses and in placing the training school for nurses on the budget system;

(d) That the board of trustees definitely study the curriculum of the training school for nurses in order to estimate the extent to which the programme of Nursing Education definitely benefits the Nursing Service in that individual hospital;

(e) That after definite knowledge of the actual cost of Nursing Education and Nursing Service is available, the board of trustees co-operate in an effort to secure governmental subsidy for the net cost of Nursing Education, which is given in the Survey in the following terms, "The net cost of educating student nurses is the difference between the total cost of her education and the monetary value to the hospital of her services;

(f) That the board of trustees be notified of the appointment in each province of the Provincial Joint Study Committee and their interest and co-operation solicited.

Financial Aid from Government for Nursing Education

By ELIZABETH SMITH, Normal School, Moose Jaw, Sask.

Quoting the Survey, "As in the case of the normal school for training student teachers; the net cost of training student nurses should be defrayed by the provincial government."

In many instances throughout the Report the Director has compared the nurse in training with the teacher in training. What are some of the points in the comparison.

1. The educational entrance re-

quirement of the teacher in training is a minimum of grade XI or three years of secondary school, while preference is given to those holding a grade XII (four years) certificate. The prerequisite for the nurse in training is left with the individual hospital. Many hospitals now require an entrance of at least grade XI. We know, however, that there still are hospitals admitting students with a lower educational standing. (We know, too, that provincial regulations in many cases require no more than at least two years of high school, which allows for many loop-holes.)

2. The instructors in teacher-training-schools are properly qualified teachers. The school is subject to inspection and supervision by the Department of Education of the province. The work of the teacher after she leaves the teacher-training-school is also inspected before that teacher is granted a permanent certificate: that is, she is serving an internship.

The instructors in many schools of nursing are individuals who have no special qualifications in teaching apart from their hospital training.

3. The elementary and secondary schools serve as laboratories in which teachers-in-training perform experiments. The hospital serves as the laboratory for nurses-in-training.

From the point of view of service the two professions are very similar: the teacher serves the whole province; the field of service for the nurse is not only the local community in which she has been trained, but the whole province and beyond.

The teacher serves the province and civilisation in caring for the health and development of the mind and body of the child. The nurse serves civilisation by caring for the health of the mind and body of men, women and children. From an humanitarian point of view, the types of service are much the same.

A student entering normal school is required to pay an entrance fee, in some provinces, fifty dollars. This

in no measure covers the cost of training the student. The remainder of the cost is borne by the provincial government.

Taking into consideration the maintenance and allowance given the nurse in some cases and the material value of her nursing services to the hospital, it has been reckoned that the cost to the hospital per annum of training each nurse is one hundred dollars. This cost is borne entirely by the local community.

By the British North America Act, education was placed under the jurisdiction of the province. The elementary, secondary, normal and technical schools, as well as the provincial university, are assisted by the provincial government. The provincial Department of Education is responsible for the curricula, inspection and financial support.

Why should the training of the nurse be practically the only phase of education in a class by itself, in that there is no state control or assistance in connection with the curriculum, qualifications of instructors or financial assistance?

Quoting the Report again:

"The adequate education of the nurse, as of the teacher, is a national enterprise entailing national obligations which should not be saddled upon the local community."

It is only reasonable to expect that a government giving financial aid to an educational institution would expect some jurisdiction in regard to inspection and the standard of training maintained by the institution. A government failing in this would be considered lax.

We might expect all students entering a training school for nurses to be required to pay an admission fee.

The school would be staffed with properly qualified instructors; that is, instructors who have not only a knowledge of the work which they are teaching, but an understanding of the principles of psychology and the philosophy of education.

There would be a staff of medical instructors, who would receive suitable remuneration, instead of a group of volunteer workers lecturing in spare time.

The school would be insured inspection and supervision, which would keep the standard up to that of the best educational institutions.

Such supervision, efficiently organised and conducted, would improve and be in the best interests of nursing education.

We should expect a government giving financial assistance to ask for

1. An approved school for nurses.
2. Definite inspection and supervision of schools for nurses.

(The Survey Report offers the opinion that such inspection of training schools for nurses should be under the control of the Provincial Council of Nurses, working in conjunction with the Public Health Departments, etc.)

Those who are opposed to financial aid from the government for nursing education may offer the opinion that such aid might be accompanied by a handicapping political interference. Such is not true in the case of the training school for teachers. Nor is this true of the hospital receiving annually a grant from the government for patient maintenance. Why then should such a condition be feared in the case of the training school for nurses?

Suppose for the present that we were granted financial aid from the government for our training schools for nurses. What effect might we expect this to have upon the training school? As has been pointed out before, if the school receives financial aid from the government it will be under the jurisdiction of the government. The school would of necessity be financially apart from the hospital.

We should expect, then, that all schools for nurses would be of the approved type. This would include all hospitals which, because of limited

facilities, are unable to give a well-rounded-out and adequate training.

It would mean that an approved school for nurses would exist for educational purposes. The hospital would serve as the laboratory for the school rather than that the school would exist in order to provide nursing service for the hospital.

There would in all probability be no more training schools for nurses than there are training schools for teachers.

Financial aid from the government would mean that there would be a uniform academic entrance requirement.

Again, to quote from the Survey Report:

"From the viewpoint of public policy and the moral and economic obligation of the State, the approved training school for student nurses should be placed in the same category and be entitled to similar financial consideration as the training school for student teachers. Nursing education should be considered an integral part of the state educational system."

THE ANALYSIS OF THE COST OF NURSING EDUCATION

Resolutions adopted by the Canadian Nurses Association following the presentation of papers, with discussion on *The Analysis of the Cost of Nursing Education*, *The Survey of Nursing Education in Canada*, are:

1. That the C.N.A. communicate with the boards of trustees of all Canadian hospitals conducting training schools for nurses, with the following suggestions:

(a) That the board of trustees study the Report of the Survey of Nursing Education in Canada, especially those sections dealing with the education of the student nurse;

(b) That each hospital undertake a definite study of nursing costs within its own institution, with a view to estimating and comparing the cost of nursing education and nursing service.

2. That the board of trustees be notified of the appointment in each province of the Provincial Study Committee, and their interest and co-operation solicited.

The Nutritionist and the Home

By MISS MARJORIE BELL, Nutritionist, Victorian Order of Nurses for Canada, Montreal, Que.

When the world today is worshipping science and "Facts" it seems strange that even among the best educated there should be almost universal disregard for the facts that science has established on nutrition. An incident in a restaurant well illustrates this point. Two fourth-year university students were overheard ordering—they chose steak, potato chips, chocolate cake, whipped cream and coffee, "Now that," said one, "is what I call a real meal." On other subjects these students would adopt almost any belief or attitude rather than be thought unscientific or behind the times, yet no meal would be considered much less of a real meal by science than the one they chose. If people who have had such educational possibilities are so ignorant what can be expected of others? This is the situation that we face. Science with a tremendous fund of knowledge which shows the relation between nutrition and health, and as Sherwin says, "In 20,000,000 homes of America a complacent tolerance for food abuses that sap the stamina of the race."

The biggest health problem of today is to make nutritional knowledge function in the lives of our people. Three world famous men in lectures given during the past year have stated what they consider would be the results if we could do it. One could quote equally effectively from Dr. Edward Mellanby when he gave the Sir Charles Hastings' lecture, from Sir Gowland Hopkins, President of the Royal Society, or from Dr. Kinlock, Chief Medical Officer of Scotland. Dr. Kinlock in his report says: "The new knowledge of nutrition has revealed what constitutes an

adequate diet for the expectant mother if her child is to develop properly during pre-natal life and how inadequacy at this period prejudices permanently both growth and health. It has shown how, owing to a faulty diet, the breast milk of the nursing mothers of the industrial classes is deficient in the mineral elements requisite for the growth of healthy infants. It has revealed the direct relationship that exists between mental alertness and an adequate diet for the growing child. It has shown how the incidence of dental caries in the community is dependent mainly on deficiency of vitamine A and vitamine D in the diet during pre-natal and post-natal life. It has demonstrated exactly how the prevention of rickets is dependent directly on the presence of activated ergosterol (vitamine D) in the diet or on the activation of the ergosterol in the skin by ultra-violet rays from the sun or from therapeutic lamps. Similarly it has shown how xerophthalmia, polyneuritis (beri-beri), scurvy and pellagra are diseases due to vitamine deficiency, and that miner's cramp, simple goitre, and the anaemia of childhood are disorders due to mineral deficiency. Of even greater moment it has shown that the immunity phenomena concerned with bodily resistance of the whole range of infectious diseases from common colds to streptococcal infections are dependent on the adequacy of the diet in relation to vitamine A and mineral constituents. In modern therapy, also, diet has taken the place of drugs as the basic requirement of treatment.

All this and much more the new science of nutrition has revealed. It is a highly technical branch of medicine requiring trained nutritionists for its practitioners. All this

newer knowledge is ready and crying aloud for application to practical living—and there is not a single nutritionist in the service of the local authorities. The local authorities instead continue to extend their hospital provision for wasting babies; to treat rickets with radiostoleum or therapeutic lamps; to provide increasingly a dental treatment service for mothers, children and the adult insured population; to augment the diet of mothers, infants, and growing children without guidance from the expert nutritionist; and to provide guidance from clinics and hospitals for the wide range of children's diseases, infectious diseases, tuberculosis, diabetes, and other illnesses whose prevention and control find in a modern nutritional service their fundamental basis.

Can a better illustration be obtained of the waste of effort and money, of the preventable dishealth, disease and death that result from a health policy that ignores the achievements of biological research and fails to seek inspiration and guidance from a biological ideal?

To realise the need for this "Modern Nutritional Service" that Dr. Kinlock speaks of one must visualise the change that has taken place in our method of selecting food. Till very recently the food of most people has been decided far more by circumstances than by choice. In the past some races have been well fed and have had excellent health just because they lived in an environment naturally providing a balanced diet. Such conditions prevail now only in a few isolated areas. Transportation, refrigeration and manufacturing have entirely altered the situation. Foods are interchanged over the whole world. Factories take these foods and put them through processes which finally give them to the public infinitely altered in appearance and value. While there is the possibility of choosing, on even limited income, almost any type of food, actually, many powerful forces operate to

direct buying and the direction is from the point of view of commercial profit not health formation.

Clever advertising sells products of little nutritional value. Bargain sales get rid of surplus stock. Many restaurants offer "specials" which give an ill balanced meal. Candy and pastry shops tempt the hungry on their way home. People are choosing too much the highly flavoured meats, the tempting, easily served white flour desserts, the appetite satisfying sweets. Whole grain cooked cereals are replaced by those so refined that they can be stored indefinitely ready to eat in packages. White bread is used instead of whole wheat. Milk and foods combined with milk seem flat and unattractive. They take time and trouble to prepare. Vegetables are used in small quantities. They are usually overcooked and have most of their flavour and minerals boiled into the water and thrown down the sink.

The result of all these influences is a diet not sufficiently deficient to bring about startling immediate results, but which when eaten over a long period is responsible for such defects and diseases as those referred to by Dr. Kinlock.

If we could have scientific knowledge guide our choice there would be the greatest opportunity for health ever known to the world.

All organisations working for public health need a nutritional service definitely aiming to spread abroad this knowledge. Left as a side issue of other services it will be neglected. Wherever prevention can be stressed nutrition has a place. It needs far more emphasis than it is getting at the present time, and the ultimate aim of every policy should be to have it taught in the schools. Why should education on such a subject be left to the chance contact with some social agency? There is no question but that it affects each and every one of us all through our lives. Constantly new discoveries are being made and details changed, but there

are well established fundamental facts that everyone should have. The theory of nutrition is not a subject which concerns girls and women only, it is equally needed by boys and men. Women are more largely concerned with spending money for food and in cooking it and should have special instruction on both these subjects. Much could also be done in schools to help little children form the right habits of eating.

At present it seems necessary to especially refer to the need for a nutritional service in all organisations supplying food to the families of the unemployed. When the money available is, as it usually is, below even the minimum necessary for maintenance, it seems unnecessarily cruel to leave the selection of the food bought to choice which is unguided by knowledge of values, for with the same sum of money tremendous variations can be made. Surely we should use science to prevent as much as we possibly can of the permanent harm which is going to be the result of this period.

Apart from the suffering and unhappiness caused by ill health there is the economic aspect. Dr. Mellanby stresses the fact that the results of a poorly balanced diet are costing our country millions of dollars annually and that most of this cost could be

wiped out by proper education. It is of course always difficult to get people to see the value of preventive programmes. Cure is so much more spectacular.

Another difficulty to be overcome is that of workers for a nutritional service. Our universities are graduating many with the theoretical knowledge of the subject, but very few opportunities have been given in Canada for them to get the practical experience which is absolutely necessary, if the most effective methods of teaching in each organisation are to be discovered. Much pioneer work will have to be done and many mistakes will be made, but nothing will ever be accomplished unless there is a beginning. The biological staff of the universities can be of tremendous value in keeping policies to sound scientific principles, and away from fads.

Sir Charles Hastings, in a lecture given on Sanitary Science in 1864, closed with words which exactly apply to our present situation in regard to nutrition. He says, "But whether England herself has the wisdom to walk in this way, and whether others follow or not therein, be assured that in the observance of these immutable principles the permanent prosperity of states is bound up."

CANADIAN NURSES ASSOCIATION

By the time this issue of the *Journal* reaches its readers the National Office of the Canadian Nurses Association will have been transferred to Montreal. In future the address of the Canadian Nurses Association and *The Canadian Nurse* will be 401 Crescent Building, Crescent and St. Catherine's Street West, Montreal, Que.

Community Needs in Nursing

By Dr. A. T. BAZIN

On January 28th last I had the privilege of speaking before the Association of Registered Nurses of the Province of Quebec. On that occasion I attempted to present an abstract of the Report on the Survey of Nursing Education in Canada. I believe that your appetites were whetted for more, and that you were stimulated to obtain and carefully study the Report, which has been available to you for now some weeks.

Tonight I propose to submit some conclusions of the Report to a critical analysis, with the hopeful expectation of our deriving some benefit therefrom.

You are all graduates of some training school for nurses, and I will assume that you are loyal to that school, that you consider it the best school in existence, and that you will do all in your power to improve the standing and prestige of that school.

But you are now out in the world. Your school gave you training and education as a nurse, but can neither ensure your success in that field nor even guarantee employment. Success, both professional and material, depends upon your own efforts, individual and collective.

Moreover you are members of a "profession." The Report (page 51) defines a profession as an "occupation which has a long-continued and rather definite preparation, and has developed a standard of good conduct, basing its work on the service idea rather than on money."

The word "service" immediately brings into the foreground the patient and the community as the object of that service. The first and final analysis of all the problems of the Nursing Profession must consider the needs of the community as of princi-

pal importance; all other considerations are subservient thereto.

Therefore this discussion will be developed in the following manner:

1. What are the needs of the community as regards nursing?
2. What training and education are essential to produce a nurse who meets those community needs?
3. What organisation is required to ensure to the community an adequate supply of the educated nurse?

1. The nursing service needs of the community:

I think it is essential that this question be clarified by defining, for the purposes of this discussion, the term "nurse" and "nursing."

The "nurse" is one who cares for the sick. In the French language the term "garde-malade" definitely states the objective of her service. Because the nurse in the past has been the one individual in the community best fitted by her training to undertake for the state, and economically for the state, duties of health inspection among school children, and of health education in communities, we have evolved the terms "school nurse" and "public health nurse." As the Report suggests, the latter might better be called "public health teachers."

A very well ridden phrase is that "prevention is better than cure," and the Survey on Nursing Education stresses in Chapter Three the urgent need of the communities in Canada of a much larger force of public health nurses. While striving for that Utopia where all disease will be prevented, we must maintain our equilibrium and recognise that the sick are now with us and must be nursed back to health.

Moreover, prevention and care go hand in hand. The well must be prevented from getting ill, and mildly ill must be prevented from getting seriously ill, and the seriously ill must be prevented from dying.

What, then, are the nursing service needs of the sick of the community? There are all degrees and grades of severity of illness. Some patients require the constant care, night and day, of an experienced and skilled educated nurse. Some patients require the attention for but an hour or two at stated intervals throughout the day, and for the remainder of the time someone to fetch and carry. Others, whose mental anxieties for one or other cause are greater than their physical disabilities, need an intelligent companion, or a supervisor of the household, or perhaps restraint by a physically and mentally competent watchman or watchwoman. We must recognise all these "needs" and many more which I have not enumerated.

We must also recognise that the graduate nurse cannot and should not be expected to meet all of these demands. In my opinion, there is very definitely a place for the practical nurse, the trained attendant or some such individual, call her by any name you wish.

But the need, and the demand, for the properly selected and properly educated graduate nurse is one which is dependent not solely upon the ability of the patient to pay the charges but because the graduate nurse can render a service which cannot be rendered by any other group.

One of the problems which confronts us is how to provide the needed graduate nursing services to those unable to pay. Certainly not by reducing the remuneration of the graduate nurse.

Perhaps some of you can remember with me the early days of the Victorian Order of Nurses for Canada. Prior to that time there were charitable organisations carrying on district nursing to a greater or less degree and more or less as a sideline to their other praiseworthy activities. Their district workers were almost altogether practical nurses. From personal experience I can testify to the devotion with which they carried

out their duties. More particularly can I recall the phenomenal work of Miss Frizzell of the diet dispensary.

In very few years the nursing work of these organisations was supplanted by the Victorian Order. Why? Because the people, and the doctors, recognised that they could get better nursing service from the graduate nurses of the Victorian Order than from the practical nurses of the other organisations. At first, the Victorian Order limited its attentions to the poor, making no charge or a nominal one of five, ten, fifteen cents per visit. But the demand for the services of these nurses spread to those who could pay more, could perhaps pay the fees for the full time of the graduate nurse of those days. And the V.O.N. was therefore compelled to arrange a schedule of prices to meet these demands. In these days of apartment houses and flats, the demand for this type of graduate nursing service is definitely on the increase.

Now, is this not hourly nursing, against which we find arrayed such an opposition?

If properly organised and controlled by the registries, I am convinced that hourly nursing would be a big success, advantageous to the nurses and welcomed by the community. But a system of hourly nursing necessarily predicates the recognition and employment of some other class of attendant. The bed-ridden patient cannot fend for herself in the intervals between the periods of hourly nursing. The ordinary, not essential, nursing needs of the patient must be met by an aide who is constantly on call. In some instances this need is met by the kindly neighbour, in other instances by temporarily employed domestic help, or by the practical nurse or the trained attendant.

Transfer the patient to hospital. She may be very ill and require the entire attention of a graduate nurse night and day. On the other hand, she may require essentially nursing services for only comparatively short

periods throughout the day. In the one instance special duty nurses are required, in the other instance the floor duty nurses assume the whole care.

Is not this latter group nursing? When an attempt is made to more systematically organise group nursing as applied to private patients in hospitals we see a powerful nurses' organisation passing resolutions condemning the scheme as against the interests of the nursing profession! I venture to predict that because of the searching revelations of the Survey such resolutions will not be upheld by any nursing organisation in Canada, and probably least of all by the association which originally approved them.

But group nursing in hospitals again predicates the employment of an increased number of nurses' aides or ward helpers to fetch and carry. This plan has already been adopted by many of our hospitals to assist in the care of patients in the public wards, the nursing of which is essentially a group nursing.

It may become advantageous to train these aides and to grant them a certificate. Then they would become available for similar work in the homes. Trained in the atmosphere of the hospital and taking their orders from the nursing staff, they would naturally fit into the scheme of hourly nursing where again they would take instructions from the graduate nurse.

I have thus presented two schemes to meet community needs which could be put into operation by the nursing profession themselves.

The Survey presents another scheme, viz., Socialised Nursing.

Now there is apt to be a great deal of misconception and therefore misapprehension about socialised nursing services just as there is much confusion about interpreting the term state medicine. Already we have a good deal of socialised nursing, in industrial communities, in private schools, but best exemplified in the Victorian Order. Nurses are engaged

on a fixed salary and nurse those patients to whom they are sent.

The Survey Report suggests a parallel as between socialised teaching and socialised nursing, the state bearing the same relation to both as regards entrance qualifications, supervision of training and education, registration, control of activities, and in return, an assured income, sick benefits and retiring allowance.

This is a scheme which will require much study. There are many hurdles to be taken before the goal is reached. Moreover, the nursing profession of themselves cannot inaugurate any such plan. In fact, my advice, if asked, would be for the present to concentrate your study upon evolving such plans to meet the nursing needs of the sick of the community as are entirely within your own power to consummate.

2. What training and education are essential to produce a nurse who meets those community needs?

This is, of course, the province of the training school. But, as I stated before, you are all graduates of some training school and I am sure your considered opinion will be eagerly sought.

Of first importance is the selection of the raw material. The chapter on Intelligence of Student Nurses is illuminating though also disheartening. Therefore the Survey emphasizes the need of intelligence and preliminary education as requisite qualifications for admission to training school, and sets the minimum as junior matriculation or its equivalent. In other words, not only is it necessary that the complete high school curriculum should have been taken, but the applicant must have been successful in passing the examinations to obtain either a school leaving certificate or matriculation into university.

In accepting this as a minimum qualification, present-day standards must be considered. It is today much more easy to obtain a high school education than it was a generation ago. Of equal importance to intelli-

gence and education is, in my opinion, personal aptitude. I have been forcibly struck by the number of nurses, pupil and graduate, who are apparently misfits. Possessed of good educational facilities and presumably of normal intelligence, they yet fail to appreciate the necessity of nursing the patient rather than the disease. Probably the "system" is at fault, but we want nurses who can on occasion rise superior to the "system."

And because I believe personal aptitude is so essential a qualification and that this can be ascertained only by contact with the patient, I am entirely opposed to the suggestion that a period of instruction outside the hospital should be the first part of the training. During the period of probation the student nurse should repeatedly come in contact with the patient. Decision can then be made, by herself or by those in authority, as to whether she is a square peg in a round hole. Much grief to all concerned will thereby be avoided.

It is not my intention to draft a curriculum. But I think we must remember that we are considering the nursing needs of the *sick* of the community, and I believe that training schools of hospitals are primarily interested in educating their student nurses to that end.

Whether the graduate, with or without post-graduate experience in nursing the sick, decides to go into some other branch is not the concern of the training school nor should it influence the shaping of the curriculum. The special training for special spheres of activity should be the concern of post-graduate studies. But the training school curriculum should embody more than perfection in technical duties; there should be in addition a real education in the principles underlying the application of these technical skills.

Moreover there should be inculcated in the students a realisation that it is the patient—a human being—who is to be nursed back to health: health of mind as well as of body. There-

fore the curriculum must embrace the fundamentals of psychology, of sociology, of preventive medicine or public health, for every graduate nurse in her sphere of influence is and should be looked upon as an apostle of health.

The Survey forcibly draws attention to the criticism that our student nurses get too much theory. But the Survey rightly points out that the fault lies in too much theory of the wrong kind. Practice is but applied theory, and intelligent practice requires an understanding of the related theory.

The curriculum is overcrowded. There is too much teaching and too little opportunity for learning—and learning is the basis of education.

I believe that the first important step is to put our student nurses on an eight-hour day. Next, to rearrange the method of instruction so that non-essential details will be deleted from the curriculum. Finally, to demand from the students a knowledge derived from study and contemplation. Progress in her education should be tested by examination, and graduation and diploma would depend, not upon the period of time spent within the hospital walls, but upon her mastery of the subject according to the standards of the individual school.

When I advocate an eight-hour day for student nurses I do not extend that to graduate nurses. Like Medicine, the profession of Nursing is an arduous one, and will always be so.

If a young woman takes up Nursing simply as an occupation and not with the idea of service, she will utterly fail, and the service ideal which characterises the members of a profession knows no trades union limitations of hours of energy expended.

The primary responsibility of the training school is to educate its students, and this cannot be adequately accomplished with young women physically and mentally wearied with long hours of duty. With such an arrangement it will easily be seen

that hospitals would have to employ more graduate nurses in order to properly care for the patients. Now, such an educational plan costs money, and this cost should not be saddled upon the patient. Hence the recommendation of the Survey that the net cost of educating student nurses should be a charge on the state just as is the net cost of educating student teachers.

Just a word about the small hospital training school. Chapter Twenty-three (Some Comparative Costs) covers that question sufficiently. None of the arguments put forward by the advocates of the small training school are of much weight if one accepts that the purpose of the training school is to educate the graduate nurse. The best plan for the elimination of the small training school is to demonstrate that the cost of nursing with graduate nurses and ward helpers is less than that of running a proper training school.

3. What organisation is required to ensure to the community an adequate supply of the educated nurse?

Perhaps this question is superfluous at this time of unemployment among graduate nurses. So let us consider this point first. It must be remembered that unemployment among nurses was acutely felt in 1929, one year before the general financial depression became apparent. Therefore, though we may confidently look forward to the restoration of normal conditions in general prosperity, it must be conceded that the correction of unemployment among nurses will not necessarily result.

In Chapter Four the Survey states the reason for this unemployment. Over-production of graduate nurses: an increase of 300 per cent. during an increase in Canada's population of only 22 per cent. is entirely to blame.

It matters not that many of the 30,000 registered nurses, and 3,000 graduate nurses not registered, are below the desired standard; they all compete under the present system of

registry, whether it be professional, alumnae, or hospital registry.

To be quite frank, I cannot foresee how the community can possibly absorb all of this number for some years to come. Even though all the training schools reduce their classes by one-half and the hospitals employ more graduates for floor duty, even though many of the smaller hospitals decide to abandon their training schools, it will be three years before the full effect of these changes is appreciated.

In the meantime, is there not a possible danger that the pendulum may swing to the other extreme, that young women of intelligence, noting the plight of so many unemployed graduates, will hesitate to enter upon a nursing career and the training schools will find themselves unable to fill their classes with suitably qualified candidates?

The Survey points out that improper distribution has something to do with unemployment, that many nurses in the larger cities are idle while patients in the rural districts are unable to secure graduate nursing services.

The Survey also suggests two methods by which not only unemployment among nurses will be alleviated but by which also the community, the whole community, will be better served.

These suggestions are:

1. A reorganised Registry.
2. Socialised Nursing.

But neither of these suggestions will solve the problem of an over-supply of graduate nurses. The reorganised registry cannot create patients, and the state under a scheme of socialised nursing will most certainly not enroll a surplus staff. But both of these suggestions point primarily to better service to the community, and secondarily to the improvement of conditions for the nurses.

With reorganisation of the registry you can immediately get busy. A careful study of Chapter Fourteen

will suggest the modifications which you may consider as at first advisable and those which will later evolve.

There are certain essential requisites:

1. A committee to assist and uphold the registrar.
2. A definite understanding of fair play as between the registrar and the registrants, but equally between the registrants and the registrar.
3. The registration of all those who care for the sick for hire.

Such a registry will certainly get the support of the community and of the medical profession.

I have tried to present some of the problems. I fear I have done so very badly. I have perhaps taken the part of the "Devil's Advocate" in dealing with the question from the point of view of the community, instead of approaching from that of the nursing profession. Possibly that is why my utterance has been so halting and undecided.

In concluding, I am prepared to reaffirm some opinions on these nursing problems which I formulated and openly expressed from time to time during the past half dozen years. I realise that there is some hardihood in so doing in the face of the sweeping denunciation in the Survey of opinions as against deductions from factual data.

In the words of Lord Moynihan, "Statistics may be made to prove anything, sometimes even the truth."

I fully acknowledge that the information gleaned by the Survey has modified my views in certain detailed respects.

But I still hold to the following fundamentals:

1. That the education of the nurse to intelligently care for the sick is the essential job of the training school.

2. That the needs of the sick of the community should be the measure indicating the type of instruction required, the content of the curriculum and the duration of the course.

3. That the status of the profession, in the opinion of the public and in the eyes of prospective pupils, will be in proportion to the type of service rendered, and not due to any artificially produced university standing or other padding.

4. That training for special activities should be post-graduate instruction, and that these objectives should not influence the basic curriculum of the training school.

5. That the ranks of institutional nurses should be recruited from the members of the successful private duty nurse group rather than from the class recently graduated.

6. That bedside instruction is more valuable than class-room instruction and should be continuous, and undertaken by each and every staff nurse.

7. That the nursing profession has not, and never can have, a monopoly of the care of the sick, and must recognise the "nurses' aides," called by one or other name.

8. That a central, registry, under the control of the Nursing Association, and enrolling all classes of attendants on the sick, would be of distinct benefit to the community and of advantage to the good graduate nurse.

Finally: The Survey in Chapter Four states that "it is manifest that the nursing profession in Canada has evolved in somewhat sporadic fashion. Should its future evolution be more systematically and deliberately controlled in meeting the needs of the community?"

I wish to emphasize that the word used is "evolution." With some, I might say many, there exists the idea that because of the Survey Report there is imminent a "revolution" in nursing.

This would be a fatal mistake. Although it may appear that the nursing profession has developed in a sporadic fashion, it cannot be denied that it has developed, and within a comparatively few years, to something noble and grand.

"Hold fast to that which is good."

Environment—The Part it Plays in the Development of Personality

By Mrs. W. T. B. MITCHELL, B.A., R.N.

Director of Parent Education, The Mental Hygiene Institute
Chairman, Section of Education, Canadian Council on Child and Family Welfare

What is personality? Is one born with a personality or does one gradually achieve it? Are some people born with pleasing personalities—sweet-tempered, self-reliant, sympathetic, socially-minded? Are others born with disagreeable ones—unstable, dependent, distrustful, egotistical—or are all made so? If personality is a gradual development, what are the factors that determine the sort of individual produced?

These questions are of vital concern to everyone, and especially to those who control the guidance and education of young children. Let us see how they can be answered.

A careful analysis of what we mean by personality reveals it as the sum total of the habit systems of thinking, feeling and doing. These habit systems are not inherited, as such, but are gradually established in reaction to environment and training, but also in accordance with individual and social hereditary limitations. Modern scientific research has established the fact that every individual inherits a unique set of genes or potentialities for the development of characteristics. What the thinking, feeling, doing individual, as a whole, shall become—in other words, what sort of personality is developed—is determined, not only by what is inherited, but just as certainly by the conditions under which these potentialities develop. For instance, we cannot be sure of developing a characteristic simply because we inherit the co-operant genes necessary

for its growth. Human organisms are like other things in this respect. What they do or become depends both on what they are made up of and on the environmental conditions that surround them. We have much justification for thinking of the environment and training provided for the growing individual, as modifying, selective forces, for the nurture of inherited potentialities. Let us examine some of the facts that substantiate our statements.

Every normal individual comes into the world with an organic basis for the development of personality. He has a body with organs for the reception of stimuli—seeing, hearing, tasting. He has organs of response—muscles, glands. He has a co-ordinating and controlling system of neurones, spinal cord and brain. He has as part of his inherited equipment, at birth, certain protective reflexes, such as winking, sucking, crying, etc. He has inherited undeveloped aptitudes, capacities and intelligence. He has a few emotional responses, such as fear, anger and pleasure, ready to function when adequately stimulated. He has certain tendencies, variously called instincts, drives or appetites, that impel him to seek satisfaction for his self, and race preservative needs, such as hunger, sex, sleep, elimination. He has the characteristic of responding to internal and external stimuli by activity. This activity is only slightly differentiated and organised, but is easily stimulated and patterned. The infant also has the characteristic of plasticity or the ability to be modified or changed by what happens to him. In short, he is an asocial being, driven by his appetites and needs—interested only in

(One of a series of addresses by the staff of the Mental Hygiene Institute, Inc., of Montreal, in co-operation with the Department of Physical Education, McGill University, Montreal, Canada).

(Broadcast under the auspices of the National Council of Education, Montreal Committee, over Station CKAC, "La Presse," Montreal).

satisfying his desires and through his activity coming into contact with the environment, experiencing, becoming modified *and* learning.

Now this individual, with his inherited equipment and desires to self-expression and satisfaction, is born into a social setting—the home, the family. The family has standards and ideals of conduct; it has expectations for this new individual; it has definite conceptions of right and wrong behaviour. Almost immediately after birth, organised pressure is brought to bear upon the infant, in the form of routine and schedule, praise for acceptable behaviour, disapproval for unacceptable response—all directed toward making him feel, act and think in conformity with the standards of the family group. There begins almost at once a conflict between the self-expressive, self-centered strivings of the child and the repressive thwarting, socialising forces of the environment.

What happens? In the first few years these socialising influences are represented in the authoritative personal control of the parents. The first problems arise around attempts at habit formation—establishing habits of control, of elimination from bowel and bladder, the establishment of good eating and sleeping habits, habits of personal cleanliness. These habits are necessary for the health of the individual and the comfort of society. If these habits are established through a well-planned programme, consistently carried out in a home atmosphere of sympathy and understanding, affection and security, with increasing opportunity and expectation of self-direction and control on the part of the child, the foundations for a wholesome personality are well laid. Such a child will tend to accept necessary social regulation of his instinctive drives with tolerance and understanding. He will gradually learn to postpone immediate gratification for more distant, worthwhile satisfaction. He will slowly but surely

learn self-control. How does this come about?

We realise that the self-centered infant must learn to adapt himself to the requirements of the social environment and relationships into which he is born. He must live with his fellows, and in such a relation he is expected to accept and observe the rules and conventions of his social group. Failure to do so will result in the disapproval of his fellows, and this censure and disapproval wounds his self-regarding feelings. Such wounded self-feeling may evidence itself in a withdrawal from contacts and society or it may result in what is called over-compensation; that is, a marked reaction in the other direction—defensive and rebellious in appearance but frequently masking great sensitivity and hurt.

The ease with which the necessary modification takes place is dependent upon two factors — physiological make-up of the child and the type of discipline used. The active, aggressive, out-going type of child who comes into violent contact with his environment, who is inconveniencing, curious and experimental, is all too apt to get in turn an aggressive, repressive type of discipline from the adults around him. This type of socialising may make him timid, fearful or unwilling to try new experiences, or it may make him resistant, rebellious, defiant and irritable. In either case we are giving the child practice in undesirable types of thinking, feeling, doing response. We are developing unwholesome personality characteristics. These types of response will not be limited to the home, but will be carried over later on into school and business relationships. On the other hand, the suggestive, passive, imaginative, inturned type of child, whose quiet, easily managed behaviour causes so little inconvenience to the adults, is very apt to get an increasing satisfaction through their easily earned approval, through day-dreaming, and to withdraw more and more completely from real situations

and the normal satisfactions of achievements and contact with children his own age. This, too, is an unwholesome personality development.

Again, we may have in the family situation a parent who is not getting reasonable happiness or satisfaction in a normal fashion through relationships with the mate or in other social relationships. Such a parent may unconsciously warp and distort the developing personality of the child by too concentrated affection or attention, or too great anxiety or concern. This arises from the parent's own emotional discontent and conflict. Such an exaggerated relationship between parent and child tends to hamper or even to prevent the natural out-turning of the child's interest and affection to others—tends to make the child physically and emotionally dependent. This thwarting of the natural, normal tendencies of the developing individual is bound to have its effect upon his personality. Conflict arises—the child is torn between his desire to remain dependent and comfortably protected in the family relationships and his natural urge to grow up and to get an increasing amount of satisfaction from healthy outside interests and contacts.

Another frequent cause of unhealthy personality development is the personal ambitions of the parents, their efforts to get, through their children, the satisfactions of accomplishments denied them. For instance, the mother who as a child loved music and wanted to study it, but who because of financial lack was unable to do so. When this woman's child is born she determines that the child shall have the opportunity she missed. Mary shall study music. Consequently, Mary, who has only a mild interest in music, who has not inherited any particular aptitude for it, is compelled from the age of five to spend hours of practice and study daily. Do you think that such aggressive measure would be apt to contribute to a liking for music or have a desirable effect upon Mary's kind of person-

ality? Or let us consider John. John's father was one of a family of eleven—a family in very modest circumstances. John's father, who is a man of exceptional intelligence and ability, was taken out of school at twelve to help contribute to the support of the family. He was very bitter about this and determined that his children should have the education he missed. John's name was put upon the list for one of the colleges the day he was born. The necessity for exceptional scholastic achievement was kept constantly before him. John worked hard. But John did not inherit the quality of intelligence his father had. He worked terribly hard. He tried desperately to even keep up with the others in his class. In the face of repeated failure to accomplish things which he could not possibly do, in the face of disappointment and criticism of his parents because of his inadequacies, John lost every feeling of self-confidence. He began to be convinced that he was no good. Only the belated help of the Mental Hygiene Clinic, giving the father some appreciation of what was happening to this developing personality, through no fault of his own, getting the family to accept this boy's inherited limitations happily, and providing a constructive plan of development of what capacity he has, has prevented a total disintegration of good material. Is personality dependent on environment and training? We leave it to you.

Environment is too frequently thought of in terms of material factors—food, shelter, cultural opportunities. But the most potent influence in the environment—the other personalities of the home, school and work situations—are frequently unconsidered. There is no doubt then that attitudes formed in the early years of life in the complicated interaction with other individuals, during the necessary socialisation and education of the child, become integral determining factors of the mature personality. We all know individuals

whose rebellious, resistant, angry attitude toward all authority has been undoubtedly determined by the unhappy, thwarting, emotionally charged experiences of the growing-up period in the family situation. We are all familiar with people whose whole attitude toward life, whose whole personality, reflects confidence and friendliness because their early experiences have been controlled and directed by understanding affection.

From the standpoint of mental hygiene, the wholesome growth of personality necessitates understanding and applying a few general principles. The problem is to so manipulate and guide the environmental forces, including the personalities, that in the necessary process of educating or socialising the child a compromise of adjustment is achieved which is at the same time individually satisfying and socially acceptable.

Feeding the Nurses

By AGNES S. PEARSON, Nurses' Home Dietitian, Winnipeg General Hospital, Winnipeg, Man.

The problem of feeding nurses is one which is of great importance to all hospitals. Good well-balanced meals are not only essential to individuals who have to work as long and as hard as nurses do, but they play an important part in the general health, contentment and cheerfulness of the nurses.

This problem must be considered from many angles, such as, kitchen equipment, the individual interest of those responsible for preparing and cooking the food, along with the all-important question of making this an economical part of the institution. Unwise economy practised in this department usually results in a waste of food.

Institutional meals tend to acquire a sameness, as foods cooked in large quantities soon lose that touch of home preparation, which often is due to a routine menu, lack of variety in the food served, or lack of interest or care on the part of the cooks, who, very often, are more anxious to get through with the work irrespective of the taste of the finished product. Quite naturally the nurse, desiring a change, seeks the corner store where

her small amount of pocket money quickly disappears.

In our hospital we have tried to avoid the continual repetition in the meals by varying the foods, yet bearing in mind our budget. This does not interfere with the fact that we can very often serve foods which are fairly expensive, by following with less expensive foods, thus giving the desired variety.

Of so great importance is the serving of hot foods, hot, and cold foods, cold, that special attention should always be paid to this factor, or an otherwise appetising meal may be spoiled.

Foods cooked in a general kitchen may often be made more palatable and attractive by an additional touch in the service kitchen. This we do in our nurses' home kitchen with considerable success. All foods are inspected as to flavour and appearance, and sauces, relishes, greens or seasonings added. Boiled potatoes are often creamed or served with parsley sauce. Vegetables are creamed; to ice cream we add chopped fruit, maple syrup, butterscotch or choco-

late sauce. With roast lamb we serve mint sauce; with baked or fried fish, caper-sauce or relish; with roast pork, dressing or apple-sauce. Also, in our service kitchen, we make creamed soups, such as, cream of potato, tomato, asparagus, corn, lentil or pimento four times a week.

Evening meals are often prepared in our own kitchen, or the general kitchen meals added to by making creamed eggs on toast with bacon, creamed shrimp with celery and green peas on toast, asparagus served with cheese sauce on toast; ham and chicken are also creamed occasionally. Some fresh vegetable, such as lettuce, celery or tomato is always served with these meals.

Fresh vegetables are served with a variety of dressing and so far have not been prohibitive all winter. Fresh frozen fruits, that is, strawberries, blueberries and cherries have added greatly to our usual supply of apples, oranges, bananas and grape-fruit, thus making a pleasing change in the diet.

We have a few special diets that are of particular interest, such as, undernourished, reducing, gastric-ulcer and anaemia, to which special attention is paid. For the undernourished an extra lunch is served at ten o'clock every morning, consisting of hot chocolate, cocoa, milk or coffee with toast or sandwiches.

In an endeavour to make conditions more home like, the Nurses' Home china is distinctly different from that used in the hospital, and we try, as far as possible, to avoid serving the same foods as the nurse has been serving on the ward. If nurses are unable to get off the ward in time for meals they have the privilege of calling the Home, and their meals are kept hot for them until they arrive. As an encouragement to the late night nurses to eat breakfast, instead of going to bed hungry as well as tired, little extras are added.

During the winter months we open a canteen in the Nurses' Home for the benefit of the nurses. A sandwich, plain or toasted, with a choice of fillings, or cinnamon toast, wrapped in oiled paper, and a pitcher holding two cups of hot tea, coffee, cocoa or cold milk may be purchased for five cents. Cookies are sold according to cost. If a pitcher of cocoa with bread and butter, wrapped in oiled paper is desired, it costs two cents. If without funds, the nurse may have bread, butter, jam and a pitcher of tea, coffee or milk, free. The idea of the canteen is not to make a profit but to be self-supporting. This last year unemployed graduate nurses took charge from 8 until 10 p.m. They received \$1.00 a night, with the privilege of having dinner with the night nurses after the canteen closed. The graduates not only enjoyed the work, but found it a great help when they were waiting for cases, as it netted them approximately \$28.00 per month, and kept them in touch with the Nurses' Home.

All money over and above expenses is used for the nurses themselves, for instance, it paid for their Christmas party, bought the Christmas decorations for the Home, and purchased a waffle iron, which will be used in the canteen.

For class parties, dances, etc., the refreshments and punch are prepared by the class in charge.

A suggestion-box placed in a convenient corner invites criticism or suggestions re food, service, or requests for a change. These suggestions are anonymous and are given every consideration. Frequently we get "thank you" notes in this box.

The writer, having trained in this school, after taking a course in dietetics, is possibly in a unique position to appreciate the needs of the pupil nurse, and is always anxious for new ideas and suggestions that may add variety or attractiveness to the nurses' menu.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section.

Miss CLARA BROWN, 23 Kendal Ave., Toronto, Ont.

The Professional Growth of the Graduate Nurse

By ADDIE McQUHAE, Toronto, Ont.

The growth of the nursing profession may be compared to that of a tree. Long ago the seed of self-sacrificing service was planted in the fertile soil of suffering humanity, and a beautiful and sturdy tree has arisen. Many branches have gradually developed. In hospitals and homes, in offices, schools and factories, in the press, in war zones, in far-flung, isolated parts of the world, and on the high seas, nurses represent the various branches of the great tree.

In the strides of science, each branch endeavours to keep abreast of the times, taking an eager and intelligent interest in each new discovery and its development. Always alert to preventive measures and curative processes, so that in their combined contact with the universe in general, multitudes are brought into the shelter of the tree.

Countless numbers are protected from the withering heat of devastating diseases. Innumerable ones rest securely in its kindly shade till mental storms subside. It shields the children of the world from many deadly blights and perils. Its balm is infused into the hearts of the troubled and tormented. Everywhere the sheltering branches reach out like divining rods, pointing unerringly to the waters of healing.

Intelligent progress has been made in regard to the health of the worker. More merciful measures have shortened the excessively long hours of duty, and the change has been conducive to better health and more efficient work, and will undoubtedly result in prolonging the life of the nurse to a more reasonable age.

The theory of nursing has been promoted to an amazing extent. University courses, professional journals, and conventions of ever-increasing importance bespeak a world-wide interest in the vital subject.

The nursing profession is truly a majestic and magnificent old tree; bravely resisting the storms of time, and unfailingly sending forth its buds of promise. Its branches, like comforting arms, are ever extended to the afflicted of the present and the future. Its roots are deep in the past, reaching far back to the divine source of its origin, and may be described in the following lines written to commemorate the fiftieth anniversary of the Training School for Nurses, Toronto General Hospital:

Forward in the van of progress,
Zealous in each wondrous dream,
Yet forever closely clinging
To tradition's glorious theme.

Once a maiden all compassion
Ministered in love sublime,
And her candle-light comes gleaming
Softly through the veil of time.

As she soothed, in tender mercy,
Tortured moan and piteous call,
Lips of wounded ones and dying
Kissed her shadow on the wall.

And the messenger of mercy
With her cheery candle-glow—
Whence caught she the vision splendid
In the days of long ago?

Backward through the mist of ages
To an evening by the sea:
Crippled, blind, demented, dying,
Thronged the shore of Galilee.

There they sought the great Physician,
He who toiled though day had fled,
And when evening shadows lengthened
Had not where to lay His head.

And He healed them all at even,
Gave them joy and peace and rest;
Eyes long blind, in rapture witnessed
Glories of the glowing West.

Healer of divine compassion!
We Thine ancient promise claim:
"Fear not, I am with you always,
Even to the end the same."

Grant us now Thy benediction,
Bless our portals evermore,
Where diseased, and blind, and broken,
Gather as in days of yore.

May the sick and sorrow-laden
Tenderly be healed and blest,
Till the radiant hues of even
Glorify Time's golden West.

The Department of Public Information, American Nurses Association, which publishes *The Bulletin* each month, has issued a special Private Duty Number, from which the following excerpt is made, under the title "Do You Like the Title 'Clinical Nurse'?"

"A substitute for the title 'private duty nurse' is being sought by the national Private Duty Section officers. To quote the section chairman, Meda Marsh, 'Nothing is so public as a private duty nurse.' The new term, the officers maintain, should cover not only the present 'private duty nursing,' but hourly nursing, staff nursing, office nursing, group nursing, and the nurse anæsthetist. They are eager to know what other nurses in these fields think of the term 'clinical nurse,' and ask nurses to write their opinions to the national section chairman.

"At the recent conference of Private Duty Section officers, someone asked for a definition of the term 'private duty nursing.' One definition is contained in certain material provided by Mary M. Roberts, editor of the *American Journal of Nursing*, to the Committee on the Costs of Medical Care, of which she is a member. It is as follows:

"Private duty nursing, in contradistinction to institutional nursing, and as at present interpreted, is full-time graduate nurse service, for variable periods, to one patient in the home or institution. The range of demands on this type of service is very wide, calling in some instances for the highest type of technical skill and for social and psychological ability of a high order. A better term for this service is special duty, indicating the need for high type service and special skill.'"

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

The Education of the Public Health Nurse

By MARGARET KERR, Assistant Director, Department of Nursing, University of British Columbia, Vancouver, B.C.

Since the education of the public health nurse forms the topic of this paper, it would be well for us to have a definite picture in mind of who this individual is and why we are interested in her education.

It has been said by an eminent authority, "A public health nurse is much more than a graduate of a good hospital. She may be doing infant welfare, school nursing, tuberculosis, industrial or bedside nursing—an infinite variety of combinations—but she must know how to enter the homes of the simple people, she must know how to teach and advise acceptably when she gets there, she must know how to get results in her community."

How to educate the nurse to meet these diversified duties is the subject we are to discuss today. We are not concerned directly with her moral, physical or social make-up, except as each contributes to the general, rounded-out whole, which is the capable, intelligent, cultivated and pleasant public health nurse.

What do we mean by education? Chambers' Encyclopædia tells us that "in the widest sense of the word a man is educated, either for good or evil, by everything that he experiences from the cradle to the grave. But in the more limited and usual sense, the term education is confined to the efforts made of set purpose to train men in a particular way." A fuller definition that could be applied to the group we are considering today is that of Dewey: "Education may be defined as the process of the continuous reconstruction of experience with the purpose of widening and deepening its social content, the

means by which a community or social group transmits its acquired power and aims with a view to securing its own continued existence and growth."

Preliminary education—the public and high school training which every nurse should have—has as its object means whereby human beings may realise their own potentialities in order that they may become themselves. They cannot become themselves without an effort of mind and will, and the discipline by which that effort is stimulated and guided is education. The development of the mind in general consists in increase of its width or scope. The developed mind has a wider reach. Its grasp extends further over the future and draws more from the past. Its insight into reality probes deeper, and in consequence its practical control of life is greater. Moreover, the development of the mind leads to increased clearness and freedom of perception and greater fluency in the expression of those thoughts. It takes a more penetrating and concrete view of the problems of life. It pictures realities to itself more accurately and appreciates the inter-relations of these realities more clearly.

In the education of the public health nurse we face a practical matter. What is expected of her in her professional capacity? What groups will she encounter, what responsibilities must she assume for which her preliminary education and hospital training have not fitted her? What personal development needs to be encouraged so that she may meet the wide diversity of problems that will confront her? These and many other questions are included in the consideration of her education.

In a position of prime importance among the individual characteristics of the public health nurse would be placed—personality. We use many adjectives to describe the impression made on us by another—strong or weak, charming or displeasing, demanding or giving, determined or irresolute, and so forth. Personality must be educated, and personality cannot be educated by confining its operations to technical and specialised things, or to the less important relationships of life. Through meeting actual situations, through a conscious endeavour to reach the desired goal, which would be the possession of a personality that would give her the open sesame to all types of individuals, this phase of her education would proceed.

Another characteristic the public health nurse must possess is the power of judging. The possession of the faculty of deciding correctly is not innate, and although it should be a characteristic of every individual, it is peculiarly necessary that the public health nurse should be trained to discriminate and differentiate between important and more trivial details. This power of judgment comes largely through guided experience. So in the full education planned for her, the value of the recommendation of the Survey Report that she have at least one year of successful experience in private duty or institutional nursing becomes apparent.

This experience is of educational value in another direction also. In the school of life, both in teaching us how to live ourselves, how to obtain the greatest benefits from those with whom we come in contact, and how to contribute most, experience is our best teacher. Nothing has unconditional value and significance except life. All other thinking, conception and knowledge has value only in so far as in some way or other it refers to the fact of life, starts from it, and has in view a subsequent return to it.

The field work that is included in the training of the public health nurse

has the expansion of this experience as its aim. Field work that provides periods for observation only, falls short of the ideal. The actual participation of the nurse in the activities of the organisation to which she is assigned for her field experience may be a source of temporary inconvenience to that organisation, but the end result is a greater efficiency, a more complete understanding of not only the techniques involved, but also of how to meet life situations and problems.

There are various methods in which the time to be spent on field work may be arranged. There are two points to be considered in securing the balance between time spent in theory and practice. In the first place, a student who has had no previous public health experience and who has spent a relatively short time in private duty, has a very inadequate background upon which to draw. The lectures will not have as much point to that individual as to one who has had even a brief period of field training. On the other hand, the student who enters upon a period of field work without previously having any theory of public health is handicapped. Her hospital training has taught her to regard the patient as an individual, so the conception of the family as the unit to be considered is entirely new to her.

Some of the ways in which the field work may be taken will depend upon which of the two alternatives is considered of greater importance. All the theory may be taken first, or part of the field work may be taken before lectures are given and the rest at the completion of the course. There is a third method, and where it has been functioning it has proven eminently satisfactory. This is an arrangement where the field work closely parallels the theory. At one university, for example, the students worked with the various agencies during the forenoon, and spent the afternoon in lectures. The results were very satisfactory in the main, but the plan has since been abandoned because it was found the

health of the students suffered from the load they were carrying.

A scheme whereby the lectures occupied two and a half days of the week and the field work the remainder of the time proved unsatisfactory to both the field agencies and the timetable arrangements. The method that is employed at the University of British Columbia at the present time, and which seems to function satisfactorily, provides for one week of field work at the end of each month during the academic year, with a period of four weeks for rural field work at the end of the term, just preceding the annual examinations. Various other schemes have been tried out, but none appear to meet the needs of the situation quite so well. A longer academic year or an extension of the course to cover two years would provide for longer periods of field work, but under the present arrangement the eight weeks so utilised produce the best results.

In the course of her field work, it is especially valuable for the student to have an opportunity, under supervision, to carry out some form of instruction to various groups.

Perhaps to a greater extent than any other professional group, exclusive of the teachers in the schools, the public health nurse is called upon to instruct. Not only must she carry her teaching into every department of her work in the home, but also she must be qualified to impart knowledge to mothers' classes, to clubs, to teach health education in the class-room, and to be ready at all times to deliver an address. According to the Survey Report findings, 65 per cent. of the nurses engaged in public health work at the present time do not possess preliminary education sufficient to enable them to secure a teacher's certificate. Since only 58 per cent. of these nurses have taken post-graduate training in public health, there are many who are unequipped for the teaching that is required of them. While there are many nurses who have had normal school training in addition to their junior matriculation,

the minimum requirement set by the Survey Report, and thus have a distinct advantage so far as all their future instruction is concerned, definite courses in teaching methods and practice teaching should be included in the programme outlined to train the other group who are unprepared.

In addition to the teaching experience, the knowledge of how to speak in public, and the development of a self-confidence that will enable the public health nurse to express herself adequately, that will teach her how to "think on her feet," will prove of inestimable value to her. The fluency, coherence and ease of manner that is so invaluable in a speaker seldom comes naturally and must be trained. Public health nurses do not have to be finished orators, but should have an opportunity through practice to lose their inherent self-consciousness.

It is not necessary to discuss in detail all the courses that should be included in the curriculum. The fundamentals of public health and the prevention of disease, the principles of public health nursing, and many other similar phases of the work, will be found in all courses. Special mention might be made of three subjects that are vital, as they play such important parts in extending the content of knowledge of the nurse and in fitting her to meet more adequately the demands made upon her. Two of these courses are mentioned by the Survey Report as being valuable for all nurses, but more especially for public health nurses, namely, mental hygiene and rural and urban sociology. The third I would mention, which interlinks very closely with these two, is the psychology of normal people of all ages.

While the public health nurse is not being trained as a social worker in the sense that the term generally connotes, a knowledge of the interrelations of family life, an insight into the various problems that frequently confront husband and wife, parents in their relation to their children, and so forth, will make it possible for the nurse to enter into

the family and function in the rôle of adviser and assistant. Since the root of many family difficulties is to be found in financing the needs and desires of all the various members from a limited income, a sound knowledge of budgeting will provide the nurse with a key to the situation that may unlock many unexpected doors.

Combined with the study of psychology should be a more thorough grounding in sex education and its bearing on childhood and adolescence. There is much more literature available on this subject today than there was a few years ago. Every phase of it is discussed more frankly and freely, more mothers and fathers are assuming their parental responsibility in teaching their children. There remains, however, a very large field of teaching and advice-giving that comes into the province of the public health nurse.

In addition to the post-graduate education provided in many of our universities for the public health nurse, there are other means by which her education may be advanced. The institute or refresher course where all the latest developments are discussed, where the problems of the individual or the group can be aired at round-table conferences, is being utilised in many provinces and localities. The value of these refresher courses is increased, or otherwise, according to the strength of the interest taken in them by *every* member of the profession. They serve their real purpose when they rouse and stimulate the love of mental adventure so that development is a constant process. Colvin, in his book "The Learning Process," states, "the human being has an environment of tremendous complexity to which he must adjust himself, and he never can acquire all the adjustments necessary and bring them under automatic control. If his life is reduced largely to habit, it means that he has arbitrarily limited the environment to which he is to react, and, therefore, has shut out the possibility of further development."

"In this sense habit deadens and reduces the life of the individual to the level of non-voluntary activity. These considerations do not mean that the individual should not acquire a large number of habits, but they do mean that also there should be beyond the sphere of habitual activity an unlimited place for further development. The difference between the person who continues to make progress all through his life and the one whose real life is ended in early manhood is that the former always possesses an open mind and the attitude of finding in his environment further possibilities of adjustment."

The public health nurse who wishes to keep up with the nursing procession must keep herself informed concerning what is going on. John Dewey, in his "Reconstruction in Philosophy," says, "No individual or group will be judged by whether they come up to or fall short of some fixed result, but by the direction in which they are moving." One way to keep moving in the right direction is by reading the nursing journals every month. Books on various phases of nursing and parallel subjects are available in almost every library. This year we have the Report of the Survey of Nursing Education, which will provide much meat for group discussion as well as for personal study. No one of us has completed our education although we have taken numerous courses and read extensively.

There are public health nursing courses organised in many of our Canadian universities. The curricula and the courses offered may not be perfection, but they have been developed with great thought and care so that today they are very worth while. Their value increases as suggestions are received from just such a group as this. The education of the public health nurse is a mutual responsibility shared by the universities with every nurse in the field. Let us set a fair goal, the adequate professional training of all public health nurses, and strive to attain it.

News Notes

Contributors to this Section are reminded that the address of the Journal is now 401 Crescent Building, Montreal, Que. Copy for this Section should reach the Editor not later than the twelfth of each month for ensuing issue.

ALBERTA

CALGARY ASSOCIATION OF GRADUATE NURSES: The annual business meeting of the Calgary Association of Graduate Nurses was held in the Y.W.C.A. parlours on September 20, 1932. Mrs. Stuart Brown, retiring Hon. President, and Miss K. Lynn, retiring President, were presented with bouquets of roses by the members of the Association, who accorded Miss Lynn a most hearty vote of thanks for her untiring efforts on their behalf, during the term of office. Officers were elected. Committees appointed are as follows: Executive, Misses C. Dewar, O. Zimmerman, M. Fleming, I. Jackson, L. Freeman, H. Ashe, L. Cooper, L. Hawkins, H. Philip, H. Gothridge; Finance, Misses H. Ashe, H. Philip, O. Zimmerman; Entertainment, Miss W. Dowding; Sickness, Mrs. M. Blunder, Misses M. Watt and Mrs. S. Brown. Plans were discussed for a card party to be held in October. A resolution was passed that all members of the C.A.G.N. must be members of the Alberta Association of Registered Nurses.

BRITISH COLUMBIA

GENERAL HOSPITAL, VANCOUVER: Miss Grace Thompson (1928) has returned home after an interesting sojourn in Mexico City, where she was on the nursing staff of the Sanitano Cowdray—an English hospital endowed by the well-known Lord Cowdray. The head surgeon of the staff and that matron are Canadians, and many of the nurses are from the Vancouver General Hospital. Miss Jean MacKay and Miss Mildred Carpenter spent three years there, also Miss Margaret Traquare, a class-mate of Miss Thompson and who is now married. There are all nationalities on the staff and among the patients also, although Germans predominate. Ninety per cent of the employees are Mexicans, as are most of the nurses. Nursing is much the same as in Canada, Miss Thompson reports, and German and French drug preparations are used entirely. The hospital is well equipped and is in pleasant surroundings in a very beautiful city.

MANITOBA

The Manitoba Association of Registered Nurses held a regular quarterly meeting in Winnipeg on October 7th. Afternoon and evening sessions were held; at the former the business of the Association received attention, while in the evening the four delegates to the Canadian Nurses Association General Meeting gave reports.

Members of the Board, Manitoba Association of Registered Nurses, entertained at a farewell luncheon on October 6th, for Miss Jean Wilson, Executive Secretary, Canadian Nurses Association.

BRANDON: The first meeting of the Brandon Graduate Nurses Association for the year 1932-33 was held in the Public Health Centre on October 3rd. Brief reports from the conveners of the different committees were received and matters of business discussed. Misses G. M. Hall, W. Barrett, M. Gemmell, L. Stewart and J. Munroe gave reviews of various sections of the Report of the Survey of Nursing Education in Canada. At the close of the meeting refreshments were served by the downtown section of the Association.

GENERAL HOSPITAL, WINNIPEG: On Tuesday afternoon, October 18th, Miss K. W. Ellis and members of the nursing staff entertained in honour of Miss Jean Wilson and Miss Lillian Pettigrew (1931). The latter joined the National Office staff a year ago and will continue as assistant to Miss Wilson at headquarters in Montreal.

Miss Florence Hamilton (1927), of the Children's Hospital, Detroit, Michigan, visited in England and on the Continent during the summer months. Miss Grace McKeever (1921) has returned from New York and has accepted a position on the Hospital staff.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in September, 1932, were 982, six more than in August, 1932.

APPOINTMENTS

GENERAL HOSPITAL, HAMILTON: Miss Christine Livingston (1930) has been appointed to the Social Service Department at the Hamilton General Hospital. Miss Eva Bennett (1930) is Assistant Supervisor in the Out-Patients' Department. Miss P. Phillips is in charge of Second Floor, Children's Wing. Miss Mary Ward has been appointed Supervisor of the Children's Ward. Miss Evelyn Gayfer is now in charge of Ward 12. Miss Langford, who has been for several years on the staff at Mt. Hamilton Hospital, is now at the General, engaged for part time in the Operating Room. Miss Helen Gowling, who has been in the Operating Room for the past two years, has accepted the position as Supervisor of the Operating Room at the Mountain Sanatorium. Her place has been filled by Miss Gladys Hemmingway (1927).

DISTRICT 1

CHATHAM: At the monthly meeting of the Nurses Alumnae of the Public General Hospital, a Reading Club was organised for the purpose of studying different books dealing with the nursing profession. The club will meet every Friday afternoon from 3 to 5 o'clock in the Nurses' rest room at the hospital. Miss Elsie Phillips gave an interesting report of the district meeting of the R.N.A.O., held in London on September 17th, at which Miss Blanche Pardo outlined the course on Maternal Care given by the Public Health Institute at London on the two previous days. A chapter of Dr. Weir's report was capably summarised by Miss Edna Orr. A social time was enjoyed after the meeting.

DISTRICT 2 AND 3

The annual meeting of District 2 and 3, R.N.A.O., was held on October 4th at the Nurses' Residence of the Woodstock General Hospital. Miss Jessie Wilson, Brantford, in the chair. The hostesses were the Alumnae Association of the Woodstock General Hospital, and at the conclusion of an interesting session they served tea to the members and guests present, who numbered sixty-eight.

At the business meeting the following officers were elected for the ensuing year: Chairman, Miss Wilson, Brantford; Vice-Chairman, Miss A. Bingeman, Freeport Sanitarium, Kitchener; Secretary-Treasurer, Miss Edith Jones, Brantford; Chairmen of Sections, Miss Helen Potts, Woodstock (Nursing Education), Miss Mae Davison, Woodstock (Private Duty), Miss Alice Eby, Guelph (Public Health); six councillors were elected, from Brant, Grey, Huron, Perth, Wellington and Waterloo counties. A vote of thanks was tendered Miss Hilda Booth, Simcoe, who has served the district faithfully as secretary-treasurer for the past four years. Miss Helen Potts gave an interestingly comprehensive picture of the activities of the Canadian Nurses Association in convention at Saint John, with especial mention of the splendid papers given by guest speakers and nurse members in reference to Dr. Weir's Survey Report. Miss Marjorie Buck, first vice-president of the R.N.A.O., spoke on "The Problem of Supply and Demand in Reference to the Distribution of Nursing Services". Miss Buck based her remarks on the Survey Report.

GENERAL HOSPITAL, GUELPH: The annual bazaar held by the staff and students of the Guelph General Hospital was held in the Nurses' Residence on October 14th. Misses Agnes Campbell and Groenewald attended the meeting of District 1, held at London, on September 17th. Miss Olga Moffat (1931) is taking a post-graduate course at the Royal Victoria Maternity Hospital, Montreal.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Miss Ellen Ewart (1931) has entered the School for Graduate Nurses, McGill University, to take the Administrators' Course. Miss Katherine

Lawrence is taking the Administrators' Course at Western University.

DISTRICT 5

The nurses of District 5, R.N.A.O., held a meeting on September 17, 1932, at Oshawa. Miss Beamish, the president, was in the chair, and there were about 132 present. At 4 o'clock reports and matters of business were dealt with. The Permanent Education Fund Committee, now increased in number, submitted a very progressive report of activities to date. Reports and resolutions of the C.N.A. General Meeting in Saint John were read. Miss Rowan, superintendent of nurses of Grace Hospital, Toronto, spoke on "The Head Nurse; Hospital Facilities for Teaching; and The Curriculum". This was followed by an interesting discussion. The speakers in the evening were Miss Eunice Dyke, of the Health Department, City of Toronto, and Miss Jean Gunn, superintendent of nurses, Toronto General Hospital. Miss Dyke's subject was "Implications of the Weir Report," while Miss Gunn analysed the "Cost of Nursing Education". Miss Gunn announced that a study committee in each province, representing the Provincial Medical Association, the Provincial Nursing Association and the Provincial Hospital Association, will be under way this fall to study Dr. Weir's report on the Survey of Nursing Education in Canada. The Ladies' Auxiliary of St. Andrew's Church served supper. Miss McWilliams, superintendent of nurses, Oshawa Hospital, welcomed the nurses to Oshawa and helped to make the day a success.

DISTRICT 5

TORONTO WESTERN HOSPITAL, TORONTO: Graduate nurses who visited the Hospital during vacation months were: Miss Ida McAfee, Johnson City, N.Y., former assistant superintendent of nurses of the Hospital; Mrs. Davis (Wilhelmina Jones, Toronto Western Hospital, 1918), Miami, Florida; Mrs. E. Pickwood (Josephine Cameron, Toronto Western Hospital, 1919), New York, N.Y.; Mrs. Leita Ward (Toronto Western Hospital, 1918), Miami, Florida; Miss Margaret Darling (Toronto Western Hospital, 1924), Albany, N.Y.

Having completed a contract term of service in charge of an Imperial Oil Hospital in Colombia, South America, Miss Marion Wylie (Toronto Western Hospital, 1915) has returned to Toronto.

DISTRICT 10

The regular monthly meeting of District No. 10 was held on October 6th in the Nurses Residence, McKellar General Hospital, Fort William, with Miss S. McDougall in the chair. Miss Edna Howie, of Toronto, was the guest speaker. District No. 10 held a very successful bridge and tea in the Kam Club, Fort William, on September 10th, under the convenership of the Executive. The District Association is now able to fully meet its obligations to the Permanent Education Fund. Miss Catherine Lemon, McKellar General Hospital, Fort William, 1931, is taking the Public Health Course in Toronto.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

- ARNOT—On July 17, 1932, at Belleville, Ont., to Mr. and Mrs. C. Arnot (Annie Burley, Belleville General Hospital, 1928), a son.
- ASCAH—In August, 1932, at Fame Point, P.Q., to Mr. and Mrs. H. Ascah (Elsie LeMeasurer, Jeffery Hale's Hospital, Quebec, 1927), a son.
- BROWN—On July 21, 1932, at Mount Hamilton Hospital, to Mr. and Mrs. Frederick Brown (Annie Emerson, Hamilton General Hospital, 1929), a son.
- CARLISLE—On September 13, 1932, at Mount Dennis, Ont., to Dr. and Mrs. Vernon Carlisle (Marjorie Middleboro, Toronto Western Hospital, 1925), a daughter.
- CRAIG—Recently, to Dr. and Mrs. K. Craig (Marjorie Gull, Vancouver General Hospital, 1928), a daughter—Marjorie Elizabeth.
- DAWSON—On April 24, 1932, at Millbrook, Ont., to Mr. and Mrs. Gerald Dawson, Bailieboro, Ont. (Mildred Smythe, Toronto General Hospital, 1926), a daughter—Margaret Isabelle.
- HOOD—On September 10, 1932, at Kitchener, Ont., to Mr. and Mrs. Roy Hood (Hazel Knox, Hamilton General Hospital, 1928), a daughter.
- LOCKWOOD—On June 10, 1932, to Mr. and Mrs. W. E. Lockwood (Jean Motta, Winnipeg General Hospital, 1926), a son.
- LYONS—In August, 1932, at Sherbrooke, P.Q., to Mr. and Mrs. B. Lyons (Ruth Edney, Jeffery Hale's Hospital, Quebec, 1931), a son.
- NEWMAN—On September 28, 1932, at Winnipeg, Man., to Mr. and Mrs. G. L. Newman (Hilda Irvine, Winnipeg General Hospital, 1926), a son.
- OCKENDEN—On October 5, 1932, at St. Catharines, Ont., to Mr. and Mrs. S. Ockenden (Mabel Goodwin, Mack Training School, 1924), a son.
- ROBERTSON—On August 31, 1932, to Dr. and Mrs. R. B. Robertson (Charlotte Jack, Royal Victoria Hospital, Montreal, 1914), a son.
- SAMPLE—On September 26, 1932, to Mr. and Mrs. Clarence Sample (Margaret Gibson, Chatham General Hospital, a daughter—Elizabeth Wilson.
- SKILLING—Recently, to Mr. and Mrs. W. Skilling (Zella Doherty, Vancouver General Hospital, 1923), a daughter.
- STALKER—Recently, to Dr. and Mrs. S. Stalker (Irma Hyland, Vancouver General Hospital, 1929), a daughter—Ann Rosemary.
- SWIFT—In September, 1932, at Montreal, to Mr. and Mrs. C. Eric Swift (Dorothy Bowden, Jeffery Hale's Hospital, Quebec, 1922), a son (stillborn).
- VAREY—On October 5, 1932, at Toronto, Ont., to Dr. and Mrs. D. H. Varey (Eileen Stephenson, Brantford General Hospital, 1928), a son.
- WALKER—On August 3, 1932, to Mr. and Mrs. George S. Walker (Linda Tickner, Chatham General Hospital, 1928), a son—Robert Stuart.
- WEBBER—Recently, to Mr. and Mrs. C. Webber (Cassie Hunter, Vancouver General Hospital, 1918), a daughter.
- WOOD—On September 17, 1932, to Mr. and Mrs. C. D. Wood (Mabel Boyd, Guelph General Hospital, 1914), a daughter.

MARRIAGES

- ADAM—ALBUTT—On August 2, 1932, Catherine Alburt (Royal Jubilee Hospital, Victoria, 1929), to Captain J. F. Adam.
- ALLAN—KETCHESON — On September 17, 1932, Addie Ketcheson, Winnipeg General Hospital, 1929), to Thomas Allan, of Winnipeg, Man.
- ALLISON—THOROLFSON—On July 30, 1932, at Winnipeg, Man., Furbena Thorolfson (Winnipeg General Hospital, 1927), to Walter Allison.
- BENNETT—VINTINNER — On September 10, 1932, at Brookbury, Que., Ella Vintinner (Sherbrooke Hospital, 1931), to Leon C. Bennett, of Bury, Que.
- CARR-HARRIS—McDUFF—In September, 1932, at Windsor, Ont., Florence McDuff (Guelph General Hospital, 1925), to Dr. Carr-Harris, of Maxwell, Ont.
- CARSON—STEWART—On September 10, 1932, at St. Catharines, Ont., Margaret Stewart (Mack Training School, St. Catharines, 1929), to Dr. Palmer Carson, of Desboro, Ont.
- CAVAYE—KERR—On September 9, 1932, Maeford E. Kerr (Royal Jubilee Hospital, Victoria, 1928), to Douglas Cavaye, Chilliwack, B.C.
- CHRISTILAW—TAYLOR—On August 12, 1932, at Winnipeg, Man., R. Christina Taylor (Winnipeg General Hospital, 1931), to E. G. Christilaw, of Brandon, Man.
- DOLGIN—BLANKSTEIN—On August 12, 1932, at Winnipeg, Man., Eva Blankstein (Winnipeg General Hospital, 1931), to J. Dolgin, of Winnipeg.
- FLETCHER—BABCOCK—On August 11, 1932, at Odessa, Ont., Ursula Babcock (Belleville General Hospital, 1930), to Donald Fletcher.
- FLETCHER—EDE — On September 3, 1932, Wilburta Ede (Royal Jubilee Hospital, Victoria, 1928), to Walter Fletcher.
- HALLIDAY—HOLDEN—On September 3, 1932, at Winnipeg, Man., Aldythe Holden (Winnipeg General Hospital, 1931), to Mr. Halliday, of Clear Lake, Man.

- HILL—RICHARDSON**—On September 21, 1932, at Burlington, Ont., Emily Richardson (Mack Training School, St. Catharines, 1929), to Dr. N. P. Hill, of St. Catharines, Ont.
- LINTON—WAGHORNE**—On October 5, 1932, at Brantford, Ont., Madoline Lena Waghorne (Brantford General Hospital, 1928), to Rev. Byron Gray Linton, of Mahone Bay, N.S.
- MITCHELL—ARTHUR**—On September 17, 1932, at Port Arthur, Ont., Mabel Arthur (Winnipeg General Hospital, 1932), to J. S. Mitchell, of Winnipeg, Man.
- MORRISON—GRAHAM**—On September 15, 1932, at Toronto, Ont., Adelaine Isabel Graham (Toronto Western Hospital, 1928), to D. G. E. Morrison. Residing at 415 Rosemary Rd., Forest Hill Village, Toronto, Ont.
- McCULLOCH—BURD**—On August 31, 1932, Doris Burd (Vancouver General Hospital, 1929), to Lawrence McCulloch.
- O'KEEFE—FOLEY**—On September 6, 1932, at Lennoxville, Que., Marjorie Foley (Sherbrooke Hospital, 1929), to David John O'Keefe, of Lennoxville, Que.
- PALMER—MARTEINSON**—In June, 1932, G. Martenson (Winnipeg General Hospital, 1932), to Mr. Palmer, of Winnipeg, Man.
- PINKHAM—CARD**—On September 2, 1932, at Saint John, Olive Card (Winnipeg General Hospital, 1926), to William Pinkham, of Saint John, N.B.
- SAVAGE—DOUGLAS**—On September 7, 1932, at Stanley, N.B., A. Louise Douglas (Sherbrooke Hospital, 1931), to Alfred Savage, of Sherbrooke, Que. Residing at 59 London Street, Sherbrooke, Que.
- SCHMIDT—SHARPE**—In September, 1932, at Los Angeles, Cal., Margaret Sharpe (Winnipeg General Hospital, 1928), to Max Schmidt.
- SWEAT—BAILEY**—Recently, in Vancouver, Bertha Bailey (Royal Jubilee Hospital, Victoria, 1924), to J. Sweat.
- THOMAS—VOLLETT**—On October 5, 1932, at Winnipeg, Man., Evelyn Vollett (Winnipeg General Hospital, 1929), to Bruce Thomas, of Newark, N.J.
- WILSON—HOLMES**—On October 8, 1932, at Rosebank, Man., Catherine Holmes (Winnipeg General Hospital, 1929), to Storey Wilson, of Winnipeg, Man.
- WILSON—DERBYSHIRE**—On September 24, 1932, at Trenton, Ont., Amy Ellen Derbyshire (Belleville General Hospital, 1930), to Lewis Albert Wilson.
- WRIGGLESWORTH—STEPHENS**—In September, 1932, at Hornby, Ont., Margaret Stephens (Guelph General Hospital, 1932), to Clifford Wrigglesworth, of Milton, Ont.
- WOODLEY—REID**—On September 10, 1932, at Glen Morris, Ont., Margaret Reid (Brantford General Hospital, 1931), to Reginald Woodley, Boston, Ont.

DEATHS

- HICKS**—On September 10, 1932, at Toronto, Ont., Alexander Hicks, beloved husband of Ruby Creighton (Toronto Western Hospital, 1912).
- MATHERS**—On August 28, 1932, at Winnipeg, Man., Mrs. (Dr.) A. T. Mathers (Gretchen Goulding, Winnipeg General Hospital, 1918).
- McMURRAY**—In September, 1932, Mrs. McMurray (Christina Fox, Vancouver General Hospital, 1931).

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The Distribution of Nursing Services

Introduced by JEAN E. BROWNE, Director of Junior Red Cross for Canada and Nurse

Member of the Joint Study Committee, Survey of Nursing Education in Canada.

Although rumblings of dissatisfaction in regard to the distribution of nursing services have been steadily growing more insistent in Canada, the revelations of the Survey came as a distinct shock even to those who were keeping their ears to the ground. They revealed the fact that approximately 60 per cent of the people in Canada needing nursing care do not have the services of a trained nurse; yet 40 per cent of private duty nurses are continuously unemployed.

What is the explanation? A density map in the Survey Report shows that two-thirds of the nurses are concentrated in 25 cities which make up one-third of the population. People in rural areas are obviously not well served. There is also evidence that only three out of eight patients of moderate means who need the graduate nurse are able to engage her.

Unthinking people have been prone to blame this unfortunate state of affairs solely on the nurse. They have said she would not face the hardships of rural nursing, that she preferred to live more at ease in cities. Those who know rural conditions in Canada realise that it is, for the most part, impossible for a free-lance nurse to settle in a rural community and earn a living. Again, the unthinking have assumed that all would be well with the patients of moderate means if the

nurse would reduce her fees. The Survey has made a very detailed report on the income and savings of private duty nurses. The median annual income for Canada was \$1,022. This amount includes the equivalent in money that otherwise would have been paid by the nurse for lodging, board and laundry if she were not on nursing duty. The actual cash received by the nurse is, therefore, several hundred dollars less than the amount stated. It is manifest that on this salary it is impossible to make any provision for the future. Indeed, to quote from the Report: "Many private duty nurses see economic disaster staring them in the face and not a few are deeply worried by the spectre of a poverty-stricken old age." In these circumstances, the reducing of fees is obviously not the solution of a general and distressing social problem.

An informed public sentiment is beginning to take shape, looking towards some form of co-operative effort as the way out. The Survey crystallizes this sentiment in a definite scheme of socialisation of nursing services which would largely bridge the gap between the needy patient, unable to pay graduate nursing fees, and the unemployed graduate nurse unable to market her services in 60 per cent of the cases of illness.

Some good people are almost stampeded by this term "socialisation." They fear it is synonymous with communism, and sniff a men-

ace associated with it. Socialisation of health services is not new in principle in Canada. We have examples of it in every public health department, and in every province where the Workmen's Compensation Act is in operation. The extension of this principle to the distribution of nursing services among all the people of moderate means in Canada who need such services, is the original contribution of the Survey. Apparently it is much needed, for according to evidence reported to the Survey by social workers, about 50 per cent of the families in Canada live on an annual income of approximately \$2,000 or less. After meeting the costs of shelter, food and clothing it is obvious that such families have practically nothing left for hospital, doctors', nurses' or dental charges.

The whole plan of socialisation of nursing services dealt with in the Survey Report depends on a scheme of Compulsory Health Insurance under defined income limits for three classes:

- (a) Wage-earners
- (b) Salaried people
- (c) A class enjoying certain financial independence in the sense that they belong to neither of the above classes, such as small merchants, retailers, farmers, etc.

The plan could be financed by contributions from the following sources:

- (a) The insured
- (b) The employer (in the case of salaried people and wage-earners)
- (c) The Provincial Government
- (d) The Federal Government (if possible)

This scheme is an extension of the principle of Social Insurance which was developed first in Germany nearly fifty years ago. At this stage it was limited to Indus-

trial Accident Insurance, the forerunner of our Canadian Workmen's Compensation Acts, and to what was called Compulsory State Sickness Insurance. Since then social schemes of Old Age Pensions, Widows' and Orphans' Pensions, Mothers' Allowances and Unemployment Insurance have been worked out in various parts of the world.

The desirability of tracing sickness first of all, preventing it whenever possible, and treating it when prevention has been unsuccessful, are fundamental problems. That nursing has a large part to play in both the preventive and curative aspects cannot seriously be doubted. But nursing is only part of the scheme as indicated in the Weir Report. The Report states that complete health service should be provided.

- (1) Hospitalisation, Medical, Nursing and Dental.
- (2) All members of the family should be included.
- (3) Home as well as hospital service: full-time nursing, hourly nursing, visiting housekeepers, etc.
- (4) Clinics: pre-natal and post-natal and public health teaching.

The question which I am sure presents itself to this practical audience in connection with such a scheme is: how to prevent the abuse of this system through malingerers or from a desire on the part of some of the insured to get "their money's worth." The Survey Report recommends charging a nominal fee, on a percentage basis of the cost of nursing care.

But the social worker may object—"If your family had no money, how could it pay?" Obviously it could not pay any more than, under present conditions, it could pay for health services or for clothing, groceries, etc. To provide against

unemployment contingencies, the Survey Report recommends that it might be advisable to insert a three months' or so "carrying period" in the Insurance Act. Furthermore, state health insurance is designed particularly to meet the health situation as it affects people of moderate means, or about the middle 50 per cent of the population. A family of five, belonging to this class, would ordinarily pay, under present conditions, nearly fifty dollars annually in dental bills alone, and according to evidence submitted by a number of doctors to the Survey, this amount paid towards a state health insurance scheme should obtain a complete service, including medical, dental, nursing and hospital care. The Survey does not vouch for this statement, as it repeatedly states that the working out of these details must be left to actuarial investigation.

To many nurses, compulsory health insurance in Canada may have all the novelty of a completely new idea. Nevertheless, investigations have been taking place in British Columbia, Alberta, Manitoba and Quebec. In February, 1929, a Royal Commission was appointed in British Columbia to enquire into the matter. The Commission presented a Progress Report on February 11, 1930, to the effect that "there is justification and a general demand for the introduction in British Columbia of an economically sound and equitable public health insurance plan" and the Alberta report on an "Inquiry into Systems of State Medicine" was given in 1929. In Manitoba Dr. E. S. Moorehead, Chairman of the Welfare Supervision Board of the Provincial Department of Health and Public Welfare, made an investigation "On the Feasibility of the Introduction of a Contributory Health Insurance Scheme to the Province of Manitoba" and in Quebec a Social Insurance Commission has been investigating Social Insurance for some

months. The Federal Department of Labour has also exhibited an interest in the problem and has published several pamphlets dealing with health insurance.

It looks, therefore, as if compulsory state health insurance is on the way, and we must be ready for collaboration in this great co-operative Social enterprise. In the first place, we should make every effort to see that the recommendations of the Weir Report in regard to the extension of nursing services should be incorporated, when the bills are being prepared, and in the second place, we must secure the machinery for the control and supervision of the nursing services which will be so greatly extended when provincial enactments are made.

A passive attitude to these problems now is a sin against our profession — against the courageous pioneers who preceded us, and especially against those who will come after us. The Survey Report states that it is imperative that there should be a strong nursing organisation capable of making a continuous and scientific study of the health needs of the community and of the professional and economic needs of the nurse, with a view to effecting a satisfactory adjustment between these two important factors. To this end, the following plan is recommended:

FEDERAL COUNCIL OF NURSING

This would be a creation of the Federal Parliament if possible, and subject to a Dominion Board of Control on which the Canadian Nurses Association should hold the majority representation. Representatives of the Canadian Medical Association and of leading lay organisations should also be appointed on this Board.

The Council would exercise functions of an advisory, directive, educational, research and integrating nature. Under Section 93 of the

B.N.A. Act this Council, being federal, could scarcely be clothed with powers of a legislative nature; but it would probably serve as the brain, in an advisory sense, of the various provincial councils.

The Council would be composed of only a few officials at the outset. To quote from the Report: "A director, preferably an outstanding woman educationist with a sound knowledge of nursing conditions and problems, would obviously be necessary. An assistant director, who had specialized in research and had training in scientific education, would probably be required. At least one of these officials should be a trained and experienced nurse. Such secretarial aid as was necessary should not prove a heavy item of expense. Should serious opposition to the establishment of a Federal Nursing Council receiving government assistance be encountered, this Council might be formed as a Division of the Canadian Nurses' Association.

PROVINCIAL COUNCILS OF NURSING

These Councils would be created by provincial enactments and would exercise function, with the advice of the Federal Council discussed above, chiefly of an executive and administrative as well as educational nature.

Compulsory registration with these councils of all who care for the sick for hire—including attendants, visiting home helpers, practical women as well as trained nurses—should be adopted.

The prime function of provincial councils would be to organise and supervise the work of private duty nurses and various types of attendants who care for the sick for hire. Private duty nurses, working directly through local or district registries as part of the provincial organisation, could be given continuous employment on a regular salary basis. These district regis-

tries would serve as branches of the provincial council, working under the direction and supervision of the latter, and bringing the types of nursing services required to the homes of patients. The adequate placement of these services would be largely conditioned by the studies of local nursing needs made by provincial councils and by the establishment of effective contacts with the medical profession, training-schools, hospitals, departments of health, and with other agencies concerned with the care of the sick.

The question arises as to whether all private duty nurses should be obliged to work under the direction of the Provincial Council of Nurses, and if so, would there be sufficient employment to keep all those nurses continuously engaged. The following aspects should be emphasized:

- (a) Nurses who prefer to remain "free-lancers" would be permitted to do so, but patients of the insured class obviously would not engage free-lance nurses.
- (b) Medical evidence, confirmed by the laity, shows that the majority of patients in Canada generally who need the services of the trained nurse are now unable to engage those services. It is probable that under a plan of social science insurance all the trained private duty nurses now available could, under an adequately organised and controlled system, be given employment of a reasonably continuous nature.
- (c) The Provincial Council and Nursing Registries should supply a scientific Nursing supervision as a reasonable assurance of efficient nursing services.
- (d) A Provincial Board of Nursing Control, the creation of

the Provincial Legislature, should be established to advise and control the Provincial Nursing Council. This Board should be free from political intervention and should be as autonomous as a University Board of Governors. As the problems to be dealt with are primarily those of the nurse, her profession should hold the majority representation on this Board. The nurse members might be appointed for a term of years by the Provincial Nurses' Association. The Provincial Government, the Provincial Medical Association and the laity should also be represented on this Board.

- (e) The chief duties of the Board would be administrative, including the appointment of the Provincial Director and other necessary officials, such as the Inspector of Training Schools, Supervisors and District Registrars.

DISTRICT REGISTRIES

Registrars should be specifically trained for their work.

The well-organised and efficiently conducted Registry of Nurses should act as a liaison officer between the health needs of the community and the proffered services of the nurse. More and more should the modern Registry attempt to become an impartial and efficient vocational placement bureau. Its chief aim should be to equip itself to select and allot the right kind of nurse to the type of case that can profit most from her specific training, abilities and temperament, and supply constructive leadership for private duty nurses.

These Registries would be under the supervision of the Provincial Council of Nursing and would supply the nursing contacts with

various classes of the community. Various types of nursing services should be made available, such as visiting nursing, hourly nursing, daily nursing, special services such as surgical, maternity, pædiatric and so forth.

Registries should be established in the less populous areas — especially those outside of, as well as within, rural municipalities — and the services of nurses made available under controlled and supervised conditions, to the rural population.

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It was generally recognised by the members of the Joint Study Committee that Professor Weir came to his task of conducting the Survey with a completely open and unprejudiced mind. It was interesting to watch, as his investigation proceeded, how the evidence which he collected gradually changed his attitude of neutrality to one of keen and understanding sympathy towards nursing. In the end he emerged as a champion of the trained nurse. Who can doubt it who reads his prophetic words regarding the role of the nurse of the future: "But who else than the trained nurse can possibly be in the strategic position to act as liaison officer between the 'values and virtues' of the old and rapidly passing school of medicine and the scientific efficiency of the new? No one but the nurse is in the field or available for this supreme venture. If she fails, the case is lost by default. Nor can she succeed unless she be competent to carry out in the sick-room the instructions of the modern specialist in the spirit and with the humanitarian touch of the erstwhile medical generalist. Unless she be a woman of superior capacity, thoroughly educated in her art, there can be little likelihood either that the best of the old will be maintained or that the best of the new will be added."

SUPPLY AND DEMAND

By KATHLEEN W. ELLIS, Superintendent, School for Nurses, Winnipeg General Hospital, Winnipeg, Man.

The principal speaker of this session has reviewed certain phases of the Report of the Survey of Nursing Education in Canada and has touched upon pertinent facts dealing with supply and demand. She has described, on the one hand, the inadequacy of the qualified nursing service as available during acute illness to only slightly more than half, or 60 per cent, of the population in Canada, and on the other, the lack of employment as continuously affecting 40 per cent of nurses in Canada.

It is well to bear in mind that these figures have been computed from an analysis made of conditions which existed in so-called normal times, a period between inflation and depression. A true picture, if drawn today, would assume even more serious aspects. The study of supply and demand involves not only the consideration of the relation between the supply of and demand for nurses but:

1. Unemployment
2. Distribution.
3. Provision for the "faithful public servant" who would perhaps gladly make way for younger members of the profession if she was financially able to do so.

UNEMPLOYMENT

Unemployment is a very stern reality in the present day as the result of which the nursing profession, in common with others, has faced and will no doubt have to face still greater difficulties.

On good authority it is stated that in a reputable hospital in the United States of America nurses

are working, thankful to have employment, for \$10.00 a month and their maintenance. In yet another institution, the hospital authorities were forced to renounce all responsibility for salaries, merely dividing any surplus, after all bills were paid, on a pro rata basis, among the employees, including members of the nursing staff. It is announced that only two resignations were received as a result of this drastic change in policy and that, after operating for nine months on this basis, the employees are now receiving 70 per cent of their original salaries. When such conditions exist perilously near home, should we not be roused to take action?

The Director of the Survey, in dealing with the whole question of supply and demand and particularly this phase of it—unemployment—emphasizes conditions as they exist for the private duty nurse. Generally speaking, a nurse, if she continues in the profession, becomes a private duty nurse, not only as soon as she ceases to be a public health or institutional worker but between engagements of a continuous nature and automatically as soon as she is unemployed. Therefore, it is apparent that the problems of the private duty nurse are those not only affecting most directly all members of the profession and the community but ones which may affect any individual member of the profession at any time. We do well to bear this in mind.

It is stated in the Report that several factors enter into the question of unemployment, *i.e.*:

1. Oversupply

2. The competition of the practical nurse
3. Distribution
4. Last, but not least, the "quality" as well as the "quantity" of the nurse permitted to graduate and pass or, in many instances, be *pushed* through, what is referred to in the Report, as "the large meshes of the R.N. examination net."

The latter factor, together with the problem of the practical nurse, has been dealt with elsewhere. Regarding the former, the Director of the Survey states that if some better method for discrimination had been used, "the present percentage of student nurses now in training, who will probably graduate as inefficient or mediocre nurses and swell the ranks of the unemployed, would have been advised to adopt a type of work more congenial to themselves and more beneficial to the community.

Superintendents of Nurses take note! While not minimizing the value of more personal effort on behalf of the less apt student, which has already been advocated by a former speaker, I, for one, am truly more apprehensive about the "misfits" whom I have been instrumental in placing *within* the profession than those *without*, for whom I have similar responsibility. It is possible that, in the day of reckoning, Superintendents of Nurses will be called upon to answer for these misfits? If this is to be the case, it is but slight consolation to feel that one will not stand alone!

That standards in schools of nursing and requirements for registration of the nurses must be raised is obvious. Also the quality of the nurse is affected by the preparation. Much has been said already on this subject. The Report recommends internship for the student who proposes taking up private duty nursing, this to be

taken during the course of training if and when much of the spade work, now being done in the school of nursing, has been relegated to the high school preparation of the candidate. For institutional nurses, supervisors, head nurses and all those taking part in the education of the student, Dr. Weir states preparation covering a period of five years is essential.

In spite of continuous and increasing conditions of unemployment, is it not true today that positions, calling for women specially qualified as teachers, supervisors of departments—such as the operating room, public health workers and even private duty nurses for special cases—are extremely difficult to fill. Registries, it is stated in the Report, show a need for well trained nurses to care for contagious, nervous and mental and pædiatric cases.

DISTRIBUTION

This plays an important part in supply and demand and is one more contributing factor to unemployment. Again it is pointed out in the Survey Report that the intelligent woman, with resources within herself, makes the best pioneer. The recommendations in this connection are that more careful consideration be given to the relationship between the needs of the community and the number of nurses graduated and that some form of adequate supervision be provided.

One would like to stress here the value, especially to the young graduate, of experience in the so-called small hospital but no longer in either small or large hospitals should students be admitted only because the hospital needs them. The Weir Report deals very definitely with obligations of the hospitals in this connection and most aptly points out that the employment of more graduate nurses on the staff of hospitals is one of the

solutions of the unemployment and overcrowding in the field of private duty. A closer co-operation between hospitals, large and small, is very essential in the realisation of this and many other common objectives.

"Hospitals should assume more responsibility for the entire nursing care of patients of average means," states the Director. While this would mean a reduction in the number of 'specials' engaged by hospital patients, it would also mean an addition to the graduate staff of the hospital." One does not wish to underestimate the service rendered by the private duty nurse, who comes as a blessing to the family and to the hospital, but it is interesting to note that the special nurse is frequently not employed in the hospital by the patient, whose actual condition demands the maximum amount of nursing care.

The psychological factor, its influence on patients, relatives, friends and even supervisors, plays an important part in many instances. One questions, therefore, whether even a very definite increase in the number of graduate nurses employed in hospitals would seriously interfere with the number of special nurses who probably will continue to be employed by the patients who, for various reasons, demand this type of service.

Dr. Weir recommends "a gradual reduction of about one-half in the student personnel and states that the proportionate increase in the number of paid graduate nurses added to the hospital staffs should be approximately 56 per cent of the above reduction." Also, the further development of group nursing and hourly nursing has been recommended.

The advantages of graduate nurse service to patients, hospitals and nurses cannot be overestimated, but those who have been confronted with the problem of re-

placement may venture to question the proportionate numerical value implied in the above recommendation.

It will be well, when placing this scheme before Boards of Trustees, if definite figures can be provided to prove that such a change of policy will result in a reduction of cost to the hospital.

SUPPLY AND DEMAND

Several recommendations, dealing indirectly with the subject of this paper, have already been submitted. There remains two which, in concluding, I wish to present for your consideration:

1. That Hospital Boards be circularized by Provincial Nurses' Associations regarding the desirability for a reduction of 50 per cent in the student nurse personnel and for whatever increase is necessary on the staff of graduate nurses.

In forwarding this letter, it is recommended that the attention of hospital authorities be called: (a) To the suggestion in Dr. Weir's Report whereby such a change in the personnel of the nursing staff might well be regarded as a reason for a slight increase in fees on the part of the hospital, and (b) the possibilities of further development of group nursing and post graduate work.

2. That Provincial Joint Study Committees be asked to make a special study of a 'superannuation scheme for nurses.

It has been said "that the reward of business for service rendered should be a fair profit, plus a safe reserve commensurate with the risk involved and foresight exercised." Surely the nurse is entitled to as much—a fair profit sufficient to permit of a safe reserve to protect her in illness, or advancing years, and commensurate with the foresight which she has exercised in securing preparation for her chosen profession.

SOCIALISED NURSING

By ELEANOR McPHEDRAN, Superintendent of Nursing, Central Alberta Sanatorium, Calgary, Alta.

The subject assigned to me has so many angles that I was at a loss to know just what might be the best point of attack in presenting the topic for your consideration. You, Madam Chairman, suggested that we find out what has been done on the subject of Health Services and Health Insurance. This is only a sketchy outline but if it will direct the thoughts of the nurses to the opening up of new fields of activity or the extension of old fields, I shall be very glad. I feel keenly my limitations. I am not a public health nurse in the accepted sense, but it has always been my nursing creed that all nurses should be teachers of health—therefore, public health nurses in the broadest meaning.

Sir Arthur Keith is quoted as follows: "We cannot escape state control in the long run—however much we may regret the loss of personal liberty which is thereby entailed. We may mould circumstances to our wills on some occasions, but in the most we are carried along on the irresistible current of affairs, the main feature of the law of evolution is its inexorability." There is beyond question both within and without the medical and nursing professions an ever increasing demand for such re-arrangement of social affairs as shall permit greater co-ordination of the available services with the community needs.

The principle of Socialised Nursing is essentially bound up with the wider topic of "State Medicine" or "State Health Services," for one cannot conceive nowadays of any health programme which does not increasingly demand the service of the nurse. She has her very definite

and universally recognised part to play in the development of any scheme of health service, whether that be a voluntary organisation as the Victorian Order or Red Cross; a Corporation Service as the Metropolitan Life; Municipal Organisations which require School and Health Department Nurses; Provincial Health Departments, with their varied activities. In spite of all these fields there is still this 40 per cent nursing service unemployed and the 60 per cent of community nursing needs not met. Also there is the severe handicapping of hospitals through the financial burden in caring for the indigent, and much more serious, there is the reluctance of people of moderate means to consult medical men or seek relief from suffering through lack of ability to pay.

One of the very urgent recommendations made by the Survey Report for the meeting of the needs of the people of moderate means in health measures, is the establishment of Health Insurance, province-wide in scope, and this solution of the problem is rapidly growing in favour, more especially in the Western Provinces. It is interesting to note what has been under consideration there during the past two years.

In Manitoba there was introduced into the Legislature in 1931, a resolution asking that the Minister of Health and Public Welfare be requested to make a comprehensive enquiry on:

- (1) Preventive Medicine.
- (2) Municipalization of Medical and Hospital Services.
- (3) Logical Health Areas.
- (4) Health Insurance and other practical methods for the more equal

distribution of the cost of illness.

- (5) Public Medical Services.
- (6) Practical methods for making specially required methods of diagnosis and treatment more readily available.

A special committee of the House was appointed to co-operate with the Minister in formulating a comprehensive health scheme for the Province, with a view to providing more efficient and economical Public Health Service.

The findings of this committee are most interesting, not only from a community point of view but also from the point of view of the nurses. All evidence pointed to one general principle: *That the cost of illness should be provided for in advance of illness and that the cost should be so distributed that it bears equitably upon all.*

The findings for Sections

- (1) Preventive Medicine
 - (2) Municipalization of medical and hospital services
 - (4) Health Insurance
- and
- (5) Public Medical Service
- concern us most closely.

In Section 1, Preventive Medicine—and please note that preventive medicine is put first—is recognised as primarily a municipal and provincial responsibility, but the committee recommends that, for reasons of economy and efficiency it be carried on in conjunction with Curative Medicine.

Section 2. Municipalization of Medical and Hospital Services. It is considered that in rural districts the work might be carried on more feasibly under the taxation method. This method of meeting expense is its greatest drawback as the increase in taxation, however slight, is apt to be met with disfavour by the ratepayers. But the establishment of a Health Insurance Plan was considered too costly for the sparsely settled district. There

would be urgent need for the education of the public so served.

With the municipalization of health service is recommended the development of an adequate visiting nurse service enabling the patient to be visited in the home and cared for there in minor illnesses, thus reducing the number of cases for hospital treatment, and consequent hospital costs.

(3) Health Insurance in some form is strongly recommended in urban areas—the details to be worked out on an actuarial basis.

(5) Public Medical Services. The responsibility for certain public medical services, notably those for mental diseases and tuberculosis, should be left as at present—under provincial control with accentuation of follow-up work and increase of clinic services as conditions permit.

In all phases there was a recognition of the value of nursing service involving an increasing demand as the programme developed. Again I call your attention to the fact that Preventive Medicine is given first place in the list.

In Alberta some four years ago a Commission was appointed to inquire into "Systems of State Medicine." After an exhaustive study of the systems in vogue in Great Britain, France, Germany, the United States, Australia, New Zealand and the various Provinces of Canada, certain recommendations were made to the Legislature. As in Manitoba, Health Insurance was recommended for the urban areas, the service provided to include medical, surgical, specialists, dental and hospital treatment, nursing, medicine and appliances in cases of sickness, maternity benefits for insured women and the wives of insured men and cash benefits in case of sickness if desirable; the system to be worked out somewhat on the lines of the Workmen's Compensation Board; the total cost to be

borne by employer, employee and the province in the ratio of two-fifths, two-fifths and one-fifth respectively. The approximate cost to the insured would probably work out to about \$1.00 per month.

For the rural areas the taxation method was favoured. It was recommended that the nucleus for a rural medical centre exists in the municipal hospitals established throughout the province — that physicians be placed on salary and that the cost be met by taxation. It was computed that the cost would average about \$4.50 per capita annually. Since this report was given the municipal hospitals have had very trying times in meeting obligations. In many cases crop failure has been such that hospital taxes could not be met, though the need for hospital care was just as great. No mention is made in the above of nursing measures except as implied in hospitalization but, as I said before, it is next to impossible to conceive of pre-natal and post-natal work, of pre-school and school work, in short of any preventive work being carried on without supervision and instruction, both of which a physician is much too busy to do.

Further, a very considerable space is given in Section IV to the public health point of view. May I quote from this: "While neither of the schemes outlined is expressed in terms of public health, it is implied in both. They are proposed, supported and defended on the ground that they will promise public health," and after a brief resumé of the report on National Health Insurance in Great Britain, 1926, "There are grounds for believing that expenditures on health, unless primarily directed to the removal of the causes of ill-health, may tend to occasion a further increase in expenditure," and again: "The great gain in public health during recent decades has been due to the application of the principle of pre-

ventive medicine, the actual prevention of disease." Does not the nurse find her place here?

In the 1932 meeting of the Legislature, a resolution was unanimously adopted calling for a commission to consider and make recommendations at the next session of the Legislature:

- (a) As to the best methods of making adequate medical and health service available to all the people of Alberta
- (b) To report as to the financial arrangements which will be required on an actuarial basis to ensure same.

British Columbia has gone a step further so far as health insurance is concerned. The final report of a Commission on State Health Insurance and Maternity Benefit was brought down this Spring (1932) and published for distribution. In this report five alternate plans are given for Health Insurance with varying costs. These were figured on a basis of two-ninths to the State, two-ninths to the employer and five-ninths to the employee. Allowing from eight to ten per cent of the fund for administrative purposes, the cost to the insured person varied according to the extent of benefit from 62 cents per month to \$1.93 per month. In the more expensive plan benefits were allowed for dependents of insured and cash allowances for maternity benefits and for time loss of insured. Little mention is made directly of nursing service or of preventive medicine.

One rather vague paragraph, 218 of the summary of recommendations, reads: "That the accumulated funds of surpluses be invested in the extension of social services for insured persons, such as providing for the inclusion of dental, ophthalmic and other beneficial health measures, including the establishment of clinics, laboratory aids to diagnosis, and periodical health examinations; or otherwise as may

be deemed advisable." In the last paragraph of the conclusion we read: "With the development side by side with the curative measures, of a sickness preventive service, an ideal system will be set up for the effectual handling of what may be described as the greatest benefit to mankind—the maintenance of good health."

Growing out of this brief resumé of the activities looking toward State Health Measures and Health Insurance is this resolution which

I leave with you for discussion:

"Resolved that the Canadian Nurses Association recommend that the Provincial Joint Study Committees be asked by the Provincial Nurses Associations to wait upon the official bodies concerned with compulsory health insurance (in the provinces which already have it under consideration) with a view to impressing upon these bodies the necessity of socialising nursing services, as recommended in the Weir Report.

DOMINION BUREAU OF NURSING, PROVINCIAL BOARDS OF CONTROL, DISTRICT REGISTRIES

By A. J. MacMASTER, Superintendent, School for Nurses, Moncton Hospital, Moncton, N.B.

I am sure that Dr. Weir has so thoroughly covered this matter in the Survey Report, and his findings and recommendations have been so excellently abstracted and reviewed by competent critics through the media of medical and nursing journals, as well as the lay press, that any attempt on my part to enlarge upon the subject, or offer suggestions, is presumptuous. I shall confine myself briefly to pertinent facts covering the proposed inauguration of the Dominion and Provincial Bureaux of Nursing, and conserve valuable time for discussions thereon.

Inquiries from authoritative sources in the United States, such as the Committee on the Grading of Nursing Schools, The National Health Library, and a study of literature dealing with the former, elicit the information that there exists the same picture of over-production and unemployment, of inequality in educational standards, and of multiplicity of inferior schools, while to offset this testimony there is ample evidence of schools doing excellent work, and

leaving a firm conviction that broadly speaking, nursing is (in spite of all its troubles) "sound at the core." A foremost American authority offers the opinion that a year from now, there will be forthcoming not only a diagnosis but a prescription for treatment.

It would appear to be the privilege of the Canadian Nurses Association to break the first soil for the cultivation of a definite national standard. Dr. Weir has brought to it, in his Report, not only a comprehensive digest of existing difficulties, but recommendations as to corrective measures, which, properly developed, will give us a compass for guidance that will be unparalleled in Nursing history.

Unfortunately, the problem has matured at a time when the country is suffering from an economic depression most seriously complicating the financial aspect about which the entire scheme revolves; while endorsing the Weir Report without reservation, we must (unless an endowment is procured wherewith to proceed without restriction) carefully analyse the Re-

port and select from it sufficient material to lay a solid foundation upon which we may build the ideal nursing service of the future.

A DOMINION BUREAU OF NURSING

The keystone of this structure should be the creation of a Dominion Bureau of Nursing, brought into being by the Federal Government. Dr. Weir suggests two bodies (a) a Dominion Board of Control and (b) a Federal Council of Nursing, to manage the national affairs, but for the purposes of the Canadian Nurses Association the functions of two such Boards could be assembled in one deliberative body named above. It should never leave the control of the Canadian Nurses Association, and, therefore, should be made up of approximately two-thirds membership derived from the various nursing organisations, and with fair representation from every province to avoid discrimination. Other appointees to the Dominion Bureau of Nursing should be representatives from the Canadian Medical Association, the Federal Government, the Victorian Order of Nurses for Canada, and the Canadian Red Cross Society. It might be advisable to include lay organisations, for example, the National Council of Women, and authorities on sociological problems from the universities.

Details immediately associated with its administration, such as officers, term of office, number of members, etc., could be best left in the hands of the National Joint Study Committee, which committee would form the nucleus of the Bureau.

The function of this Bureau should be to establish, among other things, a national standard for schools of nursing in Canada, including the educational standard of the student seeking admission thereto, and otherwise conforming to Dr. Weir's recommendations. It should be responsible for the estab-

lishment of a national curriculum, and should originate Dominion Nurse Registration Examinations, the gaining of which would automatically entitle the candidate to inter-provincial reciprocity. Other functions would include educative, advisory and administrative measures. Its recommendations would be accepted as the criterion for the Provincial Bureaux of Nursing.

A PROPOSED SCHEME TO FINANCE THE DOMINION BUREAU OF NURSING

1. Appropriate the Memorial Fund Surplus, "to assist financially any enterprise which will benefit the whole nursing profession in Canada." (Extract from Resolutions passed at C.N.A. General Meeting, July, 1928.) This balance, as at March 31, 1932, was \$1,618.52. This would prove, indeed, an ideal memorial!

2. The financing of the Dominion Bureau of Nursing might be patterned after that of the Medical Council of Canada, established in 1912 under the Canada Medical Act. This Council derived its administration expenses from the revenue received through fees paid by physicians for the privilege of securing Dominion Registration. The provisions of the Act entitled registered physicians in active practice for a stated period of years, at the time of the passing of the Act, to Dominion Registration upon payment of a fee of one hundred dollars. This precedent might apply to registered nurses holding certificates in one or more provinces or states, and who by virtue of their experience gained through years of active practice, coupled with post-graduate study, have earned similar recognition in their particular field. Nurses graduating after the establishment of the Dominion Bureau of Nursing would be required to write examinations upon payment of a scheduled fee. The proceeds from such registration fees should yield considerable

revenue with which to administer the Bureau.

PROVINCIAL MACHINERY

The Provincial Bureau of Nursing should be an enactment of the Provincial Legislature and should be composed of two separate bodies (a) a Board of Nursing Control to guide the destiny of (b) the Provincial Nursing Council. The Board of Nursing Control would have the power equivalent to a University Board of Governors, and not subject to political interference. The majority of this Board should consist of nurses appointed by the Provincial Registered Nurses Association for a term of years, a rotating term being advisable to ensure the presence of members with a working knowledge of its functions. At least one nurse member of this Board of Control should be appointed to the Dominion Bureau to act as a liaison officer. Other members of the Board should be representatives from: the Provincial Medical Association, the Provincial Government, and the laity, preferably an educationist.

The appointments from the Nurses and the Medical Associations should include the members of the Provincial Joint Study Committee. Public health, institutional, private duty, and educational sections should all have representation on this Board.

The Board of Control would be correlated to the Dominion Bureau of Nursing, and should be answerable to the Dominion Bureau for the maintenance of the high standards of efficiency set down by that body.

The financing of this Board would be negligible since the members would act in an honorary capacity only.

Subordinate to the Board of Control would be the Provincial Nursing Council, consisting of

salaried officers who will actually execute the nursing affairs of the Province. The recommended personnel of this Nursing Council includes a director, possibly an assistant director, a registrar, a clerical staff as required, an inspector of schools of nursing, and field supervisors.

The financial burden of this Provincial Council would seem at the present time almost insupportable in many provinces. Unless the governments can be induced to subsidize the project, or until some form of health insurance provides funds therefor, it must be handled by each province as an independent problem. Any province able to install the full machinery should have power to proceed; other provinces should be encouraged to select the officers most urgently needed until they can accord a full staff. Every province, regardless of resources, should engage, as the first and most important step, a thoroughly qualified inspector of schools of nursing. Two or more provinces might share the services of one inspector until such time as each province could finance independently.

COMPULSORY REGISTRATION

Compulsory registration for all who care for the sick for hire, should be the prime responsibility of the Provincial Bureaux. Some definite provision must be made for those already in the field, whether graduates or undergraduates. During this acute period of unemployment, and in an already overcrowded field, it is my personal contention that it would seem fair to concentrate on the relief of the graduates of any hospital, large or small, poorly- or well-trained, before we turn the searchlight on the vicarious problems of undergraduates and allied workers, or increase their ranks by encouraging short courses.

PROVINCIAL REGISTRATION EXAMINATIONS

These have been referred to by Dr. Weir as a "sieve with open meshes." They involve two problems:

- (1) The questioned precision exercised by Boards of Examiners in evaluating examination papers.
- (2) Widely divergent standards of the schools of nursing which produce the candidates seeking registration.

Many factors complicate the situation, for example: Marked diversity of admission to schools of nursing; limitations in training courses; lack of affiliations; faulty preliminary education, and fundamental lack of intelligence.

All these must be considered as equally responsible for our vulnerable position, rather than any intrinsic failure on the part of Boards of Examiners to perform conscientiously their duties. Until such time as the Dominion Bureau of Nursing establishes a national standard for schools of nursing, which would include entrance requirements equivalent to university matriculation, and until a standard curriculum eliminates the varied courses of the present system, no better method would appear to be forthcoming. Corrective measures would seem to indicate the employment of a trained examiner in each province for the rating of all examination papers. Toward this end we might seek the assistance of a university within each province. Supplementing this, it might be possible to arrange with the universities to apply intelligence tests to applicants seeking to enter schools of nursing.

DISTRICT REGISTRIES

We must acknowledge the inadequacies of the present system of registries. There must be, at some time, definite provision made for the installation of district registries as discussed in the Survey Report. However, until the Dominion and Provincial Bureaux are actually functioning, discussion thereon is pre-mature.

Mindful of the above, it is my privilege to submit the following

Proposed Resolutions on Section (3) of "The Distribution of Nursing Services"

Be it therefore resolved that the Survey Report, insofar as it pertains to a Dominion Bureau of Nursing, Provincial Bureaux of Nursing and District Registries be endorsed, and that the following action be taken in respect to:

(1) DOMINION BUREAU OF NURSING

That the National Joint Study Committee be asked by the Canadian Nurses Association to petition the Federal Government to create a Dominion Bureau of Nursing as recommended in the Weir Report.

(2) PROVINCIAL BUREAUX OF NURSING

It is recommended that Provincial Associations ask the Provincial Joint Study Committees to petition the Provincial Governments:

- (1) To create Provincial Bureaux of Nursing as recommended in the Weir Report.
- (2) To enact compulsory registration of all who care for the sick for hire.

THE DISTRIBUTION OF NURSING SERVICES

Resolutions adopted by the Canadian Nurses Association following the presentation of papers with discussion on The Distribution of Nursing Service — The Survey of Nursing Education in Canada are:

1. THAT Hospital Boards be circularized by the Canadian Nurses Association regarding the desirability for a material reduction in their student nurse personnel, and whatever increase necessary in the staff of graduate nurses.

2. THAT Provincial Joint Study Committees be asked to make a special study of superannuation schemes for nurses.

3. THAT the Canadian Nurses Association recommend that the Provincial Joint Study Committees be asked by the Provincial Nurses Associations to wait

upon the official bodies concerned with compulsory health insurance (in the provinces which already have it under consideration), with a view to impressing upon these bodies the necessity of socialising nursing services, as recommended in the Weir Report.

4. THAT the National Joint Study Committee be asked by the Canadian Nurses Association to study the question of a Dominion Bureau of Nursing as recommended in the Weir Report, and report back to the Canadian Nurses Association.

5. THAT the Provincial Associations be asked to instruct the Provincial Joint Study Committees to study the question of petitioning the Provincial Governments to enact compulsory licensing of all who give nursing care to the sick for hire and to report back to the Provincial Associations for action.

THE TREATMENT AND PREVENTION OF COLDS

By G. HILTON, M.D., Department of Oto-Laryngology, The Montreal General Hospital, Montreal, Que.

The word cold as used by the laity is a rather vague term, but is rendered somewhat more specific by the commonly-used phrases — head colds and chest colds. Although these terms convey to most people a definite condition, they yet may embrace many conditions of a different nature. Most respiratory infections may at one time or another during their course be classified under colds. However, in the vast majority of cases the common cold is an acute rhinitis with swelling and inflammation of the mucous membrane of the nose and often accompanied by a slight involvement of the nasal accessory sinuses.

SYMPTOMS

A cold often commences with a tickling sensation in the nose and sneezing. The nose soon becomes blocked and there is a copious

watery discharge which later becomes purulent. The nasal obstruction impairs the sense of smell and taste. Breathing through the mouth causes a dryness and irritation of the respiratory passages. Headache, malaise and often a slight rise in temperature are the usual results. The common cold in most cases subsides within a week or ten days. Some colds, however, do not subside, but lead to disease of the nasal accessory sinuses, ears, larynx, trachea or bronchi. On the other hand the early stages of the disease may be simulated by the exanthemata, influenza, asthma, nasal syphilis, nasal gonorrhoea, etcetera.

The ordinary cold in the average healthy child or adult is not a serious thing, but may be of grave import in infants by interfering with nursing, or in the aged who have not the resistance of youth.

LOCAL CONDITION

The examination of the nose at the time of a cold reveals a mucous membrane which is very red, turgid and swollen. The depths of the nasal cavities cannot be seen without the shrinking action of cocaine and adrenalin, due to the almost if not complete blocking of the nose by the engorged turbinates and mucous membrane. There will be a copious serous or purulent discharge present according to the stage of the disease at the time of examination and more or less excoriation and reddening of the skin around the nose due to the irritating discharge.

TREATMENT

Many colds could be aborted at an early period if the person afflicted were to remain in bed for a few days and follow treatment. A good hot bath and brisk rub down before going to bed followed by hot drinks and some diaphoretic, like Dover's Powders, is very beneficial. The bowels should be freely opened by a laxative followed by a saline cathartic the following morning. Inhalations of steam with a little tincture of benzoin or menthol often gives considerable relief, especially when the cold is associated with a laryngitis. The patient should be in a well lighted and ventilated room with plenty of covers on while in bed. Hot fluids only for the first day or two are advisable.

Some solution containing adrenalin or ephedrine used locally as a spray or as nasal drops gives considerable comfort by relieving the congestion in the nose for the time being.

R

Menthol
Camphor a.a., 2 grs.
Ephedrine Hydrochloride, $\frac{1}{2}$ dr.
Albolene ad, 2 oz.

Sig:—

Use as a spray or nasal drops.

Local applications of silver solutions such as 5% or 10% neosilvol is highly recommended by some. The value of vaccines during the acute stage of the disease is questionable.

PROPHYLAXIS OR PREVENTION OF COLDS

Any pathological condition in the upper respiratory tract may predispose to colds by acting as foci of infection or by interfering with the normal functions of the nose and throat. The local and often the general resistance is thereby lowered favouring invasion. People who suffer from frequent colds and who have infection in the tonsils, adenoids or sinuses, or who have nasal deformities which prevent proper nasal breathing, should have these conditions attended to.

As everyone knows, the common cold is very infectious. When one member of a family contracts a cold it is quite usual for other members of the same family to become likewise afflicted. Therefore people with colds should be very careful in their contact with others. All nasal discharges should be collected on lint or cotton and burned or otherwise destroyed. Babies should especially be protected from people suffering from a cold as babies are very susceptible to colds and prone to develop the complications following colds. The transference of a cold to others is best avoided by having the patient confined to bed for the first few days of the disease. The infectious aspect of a cold cannot be traced to any one organism but usually a combination of organisms with one predominating is the rule.

Many observers have pointed out that people more or less isolated in out of the way places and yet subject to all the predisposing causes do not suffer from colds. This is probably due to the lack of an in-

fecting agent. However, when these people come to our crowded centres of civilisation where colds are prevalent, they are very prone to develop colds, even though the predisposing causes may here be lessened. Thus one may assume that where there are crowds there are colds and to avoid colds avoid crowds.

The general resistance is a big factor in one's immunity to colds. Anything tending to lower the general resistance should be avoided and that which tends to increase the general resistance encouraged. Fresh air and sunshine are two essentials for the maintenance of the general resistance but unfortunately many people are deprived of this necessity by the very nature of their occupations and mode of living. During our long winter days in this country people with indoor occupations have little opportunity to be out in the sunshine and in many places they are subjected to an overheated, dry and vitiated atmosphere. Where time and opportunity offers, walking to and fro to work instead of using a public conveyance will help to remedy this evil. At least an hour of walking per day in the open should be the minimum. In many offices and homes the air is too warm and dry and not in circulation. The proper room temperature should be comfortable and in the neighbourhood of 68° F. Steam heating is preferable. The air should be fresh, in circulation and kept moist by having water in containers where evaporation can take place. The bedrooms should be bright and well-ventilated with the windows open during the sleeping hours. During the winter months when there is so little sunlight, a course of quartz light treatments helps to increase the general resistance if one is able to afford the luxury. Many of the larger hospitals to-day make quartz light

therapy available to their staff, internes and nurses as it raises their resistance to infections.

Exercise is important especially to those people living a sedentary type of life. This should preferably be taken in the open. If games are indulged in the clothing should not be too heavy and at the conclusion of the game when the participant is cooling off, a coat and cap should be worn. A hot bath or shower with a brisk rub down should follow. For those unable to participate in games walking is very beneficial.

Excesses of alcohol and tobacco should be avoided as they are very irritating to the mucous membrane of the respiratory tract, thereby lowering the local and general resistance of the body. Sufficient sleep and rest are essential. Errors in diet and over-indulgence in any way should be guarded against. The use of vaccines as a prophylactic measure have been very successful in some cases, although other cases seem to derive no benefit from vaccine therapy. R. Vance Ward, after three years' experience with vaccination against the common cold in a number of health services in some of the leading industries in Montreal, concludes that the stock vaccines, although not specific preventatives of acute respiratory disorders, nevertheless benefit a large percentage of people.

In conclusion one might say that the common cold is a world-wide disease not being confined to any special geographic distribution, nationality, age or sex. It is usually treated in a trivial way, often causing little inconvenience to the afflicted person, but at times producing serious and surprising complications. The incidence of the disease can be considerably decreased by proper preventative measures and the results of the infection minimized by appropriate treatment.

THE TRAVELLING CHEST CLINIC

Province of British Columbia

By J. B. PETERS, Tranquille Tuberculosis Society, Kamloops, B.C.

Some time ago a physician was appointed by the British Columbia Government to act as Travelling Health Officer and assist the doctors in the smaller centres of the province in finding and diagnosing cases of tuberculosis in as early a state as possible.

It was not until the fall of 1928 that the Tranquille Tuberculosis Society, with funds raised by the sale of Christmas Seals, purchased a portable x-ray and provided a public health nurse to assist in this work. All expenses in connection with the x-ray, the nurse's salary and travelling expenses are paid by the Tranquille Tuberculosis Society.

On commencing her duties the nurse spent a month at the Tranquille Sanatorium getting acquainted with the patients there, finding out about their home conditions, the number of contacts in the home, and any other information that might be of assistance in the finding of new cases.

Also, a list was made of cases discharged during the previous three years, and of those who had died, with all the information available. These names and information were segregated into a loose-leaf book indexed under the different towns. A search was also made in the Provincial Statistical Department of the death certificates for those dying of tuberculosis; all old records of the Travelling Health Officer were thoroughly searched, listing those with tuberculosis, all contacts, suspects and pleurisy cases, with date of last examination. This information was added to the loose-leaf book.

This book is carried to each and

every clinic, the lists checked over with the doctors and public health nurses, and arrangements made for rechecking former patients where necessary and getting the contacts in for examination. Contact cases are examined once a year whether they are negative or not: if there is anything suspicious they are returned to each clinic.

X-ray plates are taken of practically every new case, but old cases are taken on recommendation of the clinic doctor only.

Up to the time of the appointment of the nurse, and the addition of the x-ray, the clinics were held in the doctors' offices, or cases visited in their homes or in hospital. Now the clinics are held in the various local hospitals. The lady superintendents of the different hospitals cooperate very kindly, usually providing two or more rooms for the use of the clinic. The developing plant in the hospital is used, where there is one, if none the films are taken to the next centre for development. The films are left in the hospital where taken, and are available for comparison on succeeding clinics, or to the doctors if they wish.

THE DUTIES OF THE NURSE

1. The nurse is responsible for the taking of histories of all new patients. (A complete personal history is taken of each patient on their first visit to the Chest Clinic.)

2. She sees that (a) patients are admitted to the doctor for physical examination in their proper rotation; (b) all new patients are x-rayed and old patients returned for x-ray after physical examination; (c) films are developed, also marked and arranged for reading.

3. After the clinic is over, reports of each case are written for the family doctor, and reports and history cards filed. This latter is all done in Victoria.

4. The aforesaid loose-leaf book is kept up to date. New cases are listed and any changes in diagnosis noted, also the date of last examination is written in pencil of cases already listed, so that when the nurse returns to any centre it is an easy matter to remind the family doctor or public health nurse of any cases that should come in for rechecking.

5. A trip is made to the Tranquille Sanatorium whenever possible in order to keep in touch with the patients there, and admissions and discharges noted.

THE FINDING OF CASES

This is attempted in various ways:

1. Before a clinic is held in any centre a notice is put in the local paper stating that clinics are to be held on a certain date, that examinations are free, but asking that arrangements for examination be made through the family physician.

2. Through the local doctors, who are always willing and seem pleased in most instances, to check over the nurse's list of previous cases and arrange to send in any contacts or other patients that should be rechecked.

3. Through the public health nurses. In many places the public health nurses have arranged the entire clinic and made appointments before the Chest Clinic arrives. These nurses, of course, are working closely with the doctors.

Clinics are held in practically every town of any size in British Columbia, with the exception of Vancouver; all over Vancouver Island; from North Vancouver to the Alaskan border, and the interior to the Alberta border and

north to Prince George, Hazelton, etc. This means a lot of travelling. Some parts of the province are covered only once a year, others every two to six months. On a recent trip through the Kootenay and Crow's Nest district approximately twenty-seven hundred miles were travelled with two hundred and eleven cases examined in a little over four weeks. Of course this is an exceptionally scattered area.

Clinics are growing continuously, as the following figures will show: Total examinations: 1929, 991; 1930, 1,779; 1931, 2,323; 1932, 2,950. The statistical year ends August first.

In recent years on account of the alarming number of nurses who have broken down with tuberculosis, an effort is made to examine all the graduate nurses on the staff of each hospital. The nurses in training are done as a routine procedure. A number of unsuspected early cases of tuberculosis have been found in this way, but it is still difficult to persuade the graduate nurses that they should be examined. Often they will come in and be x-rayed when they will not consent to a physical examination, and there have been several that have been first diagnosed on the x-ray findings.

Before closing this article references must be made again to the public health nurses. Their unfailing keen interest and kindly help in these Chest Clinics have been invaluable. They not only look up cases and arrange clinics, but they assist in every way possible with the clinics while in progress. Needless to say it would be impossible for the travelling nurse to attend to everything in some of the larger centres.

The travelling nurse would have not only a difficult task, but a lone-some time away from home were it not for the public health nurses and the lady superintendents of the various hospitals.

Department of Private Duty Nursing

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THE INTELLIGENCE AND EDUCATION OF THE STUDENT NURSE

By MAUDE M. WRIGHT, Montreal, Que.

A great difficulty arises when an attempt is made to arrive at an improved method of selection of the student nurse. We think of the nurses of the past—grand, courageous women, with a history of self-sacrifice and endurance. The pioneer work of Jeanne Mance and Madame de la Petrie who, 300 years ago, left homes of comfort in the Old World and established hospitals at Quebec and Montreal, has given to the world the example of service embracing three centuries of Canadian history. At that time nursing was entirely in the hands of religious orders whose devotion to duty in the face of the most trying hardships and discomforts is even remarkable to this day. The tradition of loyalty and service has descended from those brave pioneers to present day nurses. Although "much water has flowed under the bridge" since those early days, yet the same characteristic essentials are needed to make the successful nurse if she is to acquit herself with honour, and add to the high ideal of the nursing profession.

What does the medical profession and the public require in a nurse? Are these requirements reasonable and progressive? What is the best method of training which

will produce nurses capable of meeting these requirements? And, finally, what type of individual furnishes the best material as a foundation upon which this training is to build? These are unanswered questions that require a great deal of thought and consideration. "Necessity is the mother of invention," and "the demand creates the supply" are old adages. This generation has two great crises: the World War and this depression—which requires even a greater courage to face. Both have brought about the emancipation of women, and many women are seeking a career in the world whose grandmothers would be shocked at even the suggestion of such an undertaking. "Blessed are the uses of adversity" is one of the proverbs, and it may be that we, as nurses, may be able to reach out and serve the sick to a greater extent than formerly, and all branches of the profession may be drawn more closely together to serve a common cause.

In my humble opinion, four essentials are necessary characteristics of the pupil nurse. One must remember that what is in the nurse-in-training will survive and grow in the graduate. The first essential is *Aptitude*; the second, *Loyalty*; the third, *Service*; and the fourth, *Education*. I put education last, for without the first three—aptitude, loyalty and service—education is

of little account. It may make the mechanical nurse, but that is not the highest ideal of the nurse. Let us deal with each separately:

Aptitude: Sympathy towards the down and out, physically and mentally; a quiet, reassuring presence. Some nurses are all heart and no head. Both are necessary, and yet each one may be a successful unit in the nursing profession. A nurse who would make a muddle of caring for a sick, nervous patient may become an excellent head nurse. She likes detail, can command others, can impart her knowledge to others. The nurse who can be versatile, meeting different types of patients, supplying what they lack, for truly the nurse feeds the mental as well as the physical condition of her patient, and carries them on to recovery. Both types of nurse are needed. Each fills her own place. And so, although the aptitude may differ according to the individual nurse, yet it must be there. Aptitude in caring for the sick is a very essential quality.

Loyalty. By loyalty I mean loyalty to those with whom the student nurse comes in contact: to the head nurse, to the patient, to one another, and to the doctor. I put the doctor last in order, for to the nurse-in-training the doctor does not come greatly into her nursing life until her last year in the school. If a nurse begins "grumbling" in her student days, she will be a capital grumbler when she is graduated. That word loyalty covers a great deal. It should be in-bred in the student nurse: stick to one another, help one another, obedience without questioning, and, in so doing, banding themselves, as nurses, together.

Unhappy will he be who lets his mind
Long dwell on troubles that we all must
find.

They are but pebbles on a pleasant path
To call us to attention, not to wrath.

Walk calmly by and leave them all be-
hind.

Loyalty to the patient, whether he be rich or poor, giving the same service, not because he is so-and-so and may make trouble, but because he is ill and needs what the nurse can give. Loyalty to the doctor, whether he is the good-looking, popular one, or whether he is Dr. Blank, who is a bit uncouth. For the nurse's own self she must not let any discrimination interfere with her service. Inwardly, she may have her favorite on a pedestal, but not outwardly.

Service comes thirdly. It is a word that means much. The nurse-in-making will be the finished product one day. An able writer has said, "Life is for growth," and it is the growing nurse who turns into the graduate at the completion of her days-in-training. Service: the nurse who has the ability to put her theory into practice, to give to the public what it requires in the nursing line, what it is able to pay for. Service: to abnegate oneself, to nurse the patient with no thought of self.

And lastly, *Education*: To work intelligently, the nurse must have acquired, at least, matriculation standing. Education comes from the Latin words *ex* and *duco*, meaning to lead forth. Education is simply a training to meet life, and there is no one who requires a better training than the nurse. Through being educated she is able to use the knowledge acquired to nurse her patient intelligently. But, first, she must have adaptability, loyalty, and be willing to serve, otherwise her knowledge is void. The higher education she has the better should she be able to use her life in the nursing service. Think of the nurses who have the higher education, those with degrees of learning. Think of those you know individually; are they the better nurses for the degree? Normally speaking, they should be, for all education should help one to live more fully. But are they better

nurses? I can think of three that I know intimately—one in administration, two in special nursing. None of them are doing outstanding work. All three are good nurses, but no better than the nurse who has matriculated. Therefore, I say, the power to use what the student nurse gains through the three years of her training does not go to the higher educated nurse any more than to the nurse who has matriculated.

Is the public asking for the higher educated nurse? It is asking for a further training in the special branches of nursing. For instance, the nurse doing public health work, school nursing, administration work, must have training in these particular branches of nursing, but this should come after graduation. Even the private duty nurse improves with experience that has come to her after graduation. When she gets away from the hospital and has to improvise and use what is at hand in the home, it is, as it were, her post graduate training.

How can the superintendent of a school for nurses weed out the misfits in her probation class? It is a difficult task, for often the nurse who in her probation days seems a misfit, has lying dormant those essentials for a successful nurse. Will intelligence tests help? More and more frequently, intelligence tests are coming to be regarded as an important type of entrance examination, or method of selection from among a multitude of applicants. This is true in a few business and industrial concerns, in some branches of the civil service, and, most frequently, in schools and colleges of various types. But first it is necessary to decide (a) how closely success in the chosen field is related to the possession of a high degree of the quality which is believed to be determined quantitatively by the test, and (b) to what extent is the pos-

session of a high degree of this quality, the most important factor in such success. At least, we must attempt to determine the relation between success on the test, with success in the undertaking on which one is about to embark. The highest correlations have been found between intelligent test scores and academic success, but, even here, we do not escape from the conflicting factors of environmental circumstances, personality and character differences, and the influence of attitudes, interest and desires. The question is always a complex one. In any attempt to estimate the value and desirability of using intelligence tests as a means of selecting the best individuals from among the applicants for entrance to a nurses' training school, these complexities remain and must be dealt with.

Although investigations of the correlation of intelligence test scores with training school success have been reported, little conclusive evidence has been found. It must be remembered that in schools for nurses where the completion of the high school course is a requisite for entrance, a considerable degree of selection from the point of view of intelligence has been effected already.

The Otis Group Intelligence scale was given to 128 student nurses and probationers. The Thurstone Cycle Omnibus Test was likewise given to the probationers and the senior nurses. One of the most interesting aspects of the results was the fact that the average score made by the probationers was twenty points above that made by any of the other three classes. This is especially interesting when we consider the fact that there has been no change in the entrance requirements during the past four years, and that the teachers declare that this class does not seem above the average in any way. The average scores made by the three up-

per classes correspond closely to Otis's norms for average unselected adults. The median score of the probationers which shows a deviation of twenty points above this level, seems thus to indicate that they are a more selected group from the standpoint of intelligence, in spite of the evidence given that no organised attempt was made to make a better selection, and that this seeming superiority has not been observed in their work. More widespread and continued testing of student nurses is the only way in which more light can be thrown on the question to discover whether the difference shown here is merely a chance difference between two groups of individuals, or whether it represents a general tendency. Only by repeated testing of the same individuals during their progress through the school for nurses can it be discovered whether or not this difference is significant of an actual decrease in the ability necessary for achievement on this test. It suggests that differences in intelligence, above the minimum standard, already assumed as a requisite for graduation from high school, do not form an important factor in the qualifications for success in nursing, and that individuals considerably below the general adult norm in intelligence are not only capable of passing the nurses' training course, creditably, and of becoming registered nurses, but that this is quite a usual occurrence. While it may be assumed

that intelligence undoubtedly is a factor in nursing qualifications, it is one whose importance is difficult to single out and measure. An attempt to determine with any degree of accuracy the most desirable level and type of intelligence to be required as a qualification for entrance into the nursing profession will be faced with many difficulties, and may prove to be of little value.

A possible hypothesis would be that differences in intelligence taken as an isolated factor, so long as the degree of intelligence remains within normal limits, do not have as much weight in determining future success in nursing as does the possession of other traits and characteristics, qualities pertaining to the physical makeup, the personality, and the acquired attitudes, interests and desires of the individual. It is in this sense that intelligence testing may prove to be a relatively unimportant and inefficient method of selection as compared with one in which an attempt would be made to define and measure whatever other qualities may prove to be more closely related to nursing ability. The intelligence test is no more a panacea than is the surgeon's knife—it is merely an instrument to be used for a specific purpose, and with full knowledge of the conditions under which it is to be used and of the benefits to be expected as the result of its use.

QUEBEC

In an effort to raise nursing education standards in the Province of Quebec, as recommended in the Report of the Survey of Nursing Education in Canada, the pass mark for registration examinations has been raised 10% during the recent session, with an increase in the percentage of failures as follows:—One hundred and forty-three nurses

wrote, and fifty-six failed to pass.

It is earnestly hoped that as time advances, the individual nurse will realise the value of nurse registration, and that she must co-operate more fully with the teaching staff of her school, so that this final "Hallmark" of distinction may be hers through merit.

Department of Public Health Nursing

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SIDELIGHTS ON SUPERVISION

By MARION NASH, Educational Director, Victorian Order of Nurses, Montreal, Que.

Perfect things do not interest me. The problem solved, the situation under control, I soon grow restive. I think that is why this job of supervising has held me for so long. There is always something new to learn, some difficulty to adjust, some better method to try out. We are still in the experimental stage, therein lies the fascination, and while I would like to see an improvement in the technique of supervision, it is my fervent hope, that we will not soon reach perfection.

Dr. Weir, in his Survey on Nursing Education, defines education as modification of conduct, and enlarges upon the fact that education is not effective unless it leads to emergence of appropriate conduct in life situations. Again Dr. W. H. Burton of Columbia University has defined supervision as an expert technical service designed to improve the efficiency of groups of workers under supervision. In other words supervision aims to help individuals to more readily modify conduct. It would appear then that, as the aim of supervision is to help the nurse, or groups of nurses, to adapt to life situations, and to grow and develop in service, the terms education and supervision are synonymous.

I think we are all agreed that on graduation the nurse's education is not complete, but if we have kept in mind during training school days

that we are preparing this young woman to meet certain life situations; if we have endeavoured to teach her how to think, not what to think, then she is ready for the great adventure. Not least among the many things she should have learned is, that education is a life long process, that her training has but pointed the way, and opened the gateway to further knowledge.

If then the young nurse is at the beginning of her career, does it not seem rational to suppose that she may need help in adjusting to the new life. We do not expect the young lawyer or physician to be ready to practise directly he graduates from university. He must spend some time in law office, or hospital, as the case may be, but the young nurse, with less education, and less preparation, is practically cut adrift, to succeed or fail. In point of fact we send forth this young woman to do something for which we have given her very little preparation. The nurse will, in the majority of cases, assume responsibility for the sick patient in the home, a difficult task requiring the exercise of many skills, and up to the present we have left her entirely alone, to carve out her own career. Our method surely indicates that we think graduation is the end result to be achieved. Do we not give the young graduate ground for supposing that her education is finished rather than just beginning on graduation day?

Nurses must face facts. Since we are all more or less imperfect,

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whenever groups of people are collected for the purpose of carrying out some specific piece of work there must be someone to co-ordinate and direct, someone to advise and inspect. This holds good in the business world and I think experience has proven that the same principle is sound when applied in the world of nursing. Modern Public Health Nursing has from its inception recognised the necessity for supervision, but the supervisor in public health nursing, as in teaching, confined herself for many years, to one phase of supervision, and that, the least important part, namely inspection. This place of supervision fell into disrepute because the supervisor very frequently thought of supervision, merely as an opportunity for criticism. Supervision is something more than this, and yet inspection is a legitimate phase of supervision.

The supervisor must survey her field, she must know the weakness and the strength of the material with which she has to work. If nursing care to the patient is included in the programme, that nursing care must be of the first quality, because, whether we will or no, the patient criticises the nurse, and is not likely to put much confidence in instruction given by a nurse who is not skilful in giving the treatment that is important to his or her recovery. The nurse's approach to the patient and family, her skill in seizing her opportunity to teach, her skill in presenting her material, her knowledge of her subject, her ability to adapt to home situations are all important factors in the making of a successful visit. The new nurse may therefore need considerable help in adjusting to new conditions and in perfecting new skills.

Most Public Health Nursing Organisations, aim to anticipate the needs of the new nurse by giving her the opportunity to observe the senior in the field, by class

room instruction and by conferences, but the supervisor must visit with the nurse in order that she may see for herself the type of work for which this nurse is best suited, and in order that she may help her over difficulties. I would like to emphasize that last phrase—the supervisor is there to help the nurse with her difficulties, not for the purpose of criticising. If the supervisor would be successful she must think with the young girl of twenty, and see things through her eyes. She must remember her own mistakes as a young graduate, and she must remember why she made those mistakes. She must keep in mind that being human, she is still liable to err. She must tread cautiously, remembering that she has the shaping of a new career, and that in these first visits she is helping to build attitudes. It is her privilege to develop initiative and executive ability, and to make or mar a precious thing. This is no task to be lightly undertaken; if however she keeps in mind that praise is more potent than blame, if she passes over the trivial errors and praises the task well done, if she leads the nurse to suggest for herself the tasks that might have been more skilfully performed, she will find that far from dreading another visit of the supervisor, the nurse will look forward to that visit as something to be hoped for and appreciated. In other words, by her sympathetic understanding of the difficulties, and tactful advice she should endeavour to instil in the nurse healthy attitudes toward supervision so that the nurse will look upon her as a friend who is ever ready to listen and advise.

The home visit has then a twofold purpose: (1) Observation or Inspection in order to collect data, and (2) Advice that will help to improve the quality of the work.

There is still a third important phase of Supervision which for want of a better term we might call

Guidance. The nurse must be stimulated to read and study. There are many things she needs to know that are not taught in the training school. Her reading must be directed, she must be stimulated to want to hear good speakers, to learn to criticize their method of approach and their method of assembling material. A library is a necessity in any Public Health Organisation; Nursing and Medical Journals should be taken, and it is part of the supervisors work to find time to read the magazines, and draw the attention of the staff to the more important articles. In order to encourage the nurses to read, we keep in our office a magazine file. A committee, appointed each month from the staff, goes over the current magazines, notes the interesting or helpful articles, lists them under headings and they are then typed for the file by the clerk. This encourages reading and enables us to have on hand valuable material, easily located for reference. Attendance at meetings always calls for a few minutes' discussion on return to the office. In this way the experience of the supervisor, or member of the staff privileged to attend, is shared by the group.

We have discussed supervision under three headings: Observation, or Inspection, Advice and Guidance, but there is a larger and more important function that is sometimes overlooked. By visiting in the home, by supervising the records, by noting the reaction of the staff to doctors, social agencies, to one another, by noting how problems, social or medical, are handled, the supervisor obtains a good idea of the strength or weakness of her particular staff. The next step must be to devise an educational plan that will meet these definite needs. Nurses whose education does not meet accepted standards might be encouraged to attend night school. Classes in Public Speaking might meet the needs of those who quail

at the sound of their own voices; in a university centre, some nurses may take one or more of the Public Health or Cultural Courses, but for many reasons these arrangements will not serve the whole group. How, then, are we going to plan our educational programme in such a way that all the staff may participate? The Victorian Order of Nurses' staff of Montreal meet the situation in the following way:

In this office the weekly district conference is used for educational purposes. The staff nurses control the meeting, re-electing officers each fall. The chairman calls for suggestions from the staff on the winter's programme. An executive meeting follows, and these suggestions are considered. When the programme is more or less organised the supervisor is invited to a meeting. She goes to this meeting knowing the needs of her staff, and if she is sufficiently skilful, the programme that is finally accepted will meet these requirements, and at the same time will have developed out of the discussion initiated by the nurses, not by the supervisor. Keeping in mind our objective, to develop the latent abilities of all the nurses, and particularly the less studious or those lacking in initiative, every nurse is encouraged to take part in the programme. In this way the timid retiring type are induced to take leading parts as well as those who are more capable.

Last winter the project was to improve our ante-natal teaching and especially the nutrition teaching. We wanted to improve these visits on several counts—

- (1) Knowledge of our subject.
- (2) Method of assembling material.
- (3) Method of approach to the individual patient.
- (4) Method of presentation.

An imaginary, young primipara

of fair education, and moderate income, was chosen, and for this imaginary patient we planned several ante-natal visits. These visits were presented in our District Office. No two visits were made by the same nurse or pair of nurses, and each visit grew naturally out of the preceding one. When we finished in June we had made to this patient seven visits and we had not yet begun to exhaust our subject. We purposely chose a patient who was normal, and a home free from social difficulties to demonstrate how many opportunities might arise for teaching the better educated patient if the nurse was prepared, and alert.

A project of this kind keeps every one interested, each one listens attentively because she is on the lookout for suggestions, she learns to listen critically and yet tolerantly, she learns to be sure of her facts, she learns how to present these facts in a convincing manner, how to hold interest, and finally she learns how to speak in public. In our office we never know when we will have visitors; the nurses are entirely responsible for the success or failure of the conference and naturally they take more interest in its success than if the responsibility rested upon the supervisor.

To summarize, the supervisor should not be content with helping the individual nurse but should, after surveying her field, plan an educational programme for the group that will strengthen the weak, and stimulate the strong. In order that this plan may be effective, considerable responsibility

must be thrust upon the staff. They must realise that the responsibility for the success or failure of the project rests upon them. The project should be chosen as the result of the nurses' deliberations.

As the purpose of the project is to help the nurse to improve her work, the supervisor should be prepared to suggest reference reading, and to confer with the nurse on her paper before it is presented in public. Discussion should follow the presentation of each paper, good points should be brought out, weak points discussed. The supervisor should take as little part in the discussion as possible, but at first it will be necessary for her to lead in the discussion and possibly to summarize. The nurse should and does experience a great deal of satisfaction as the result of her achievement.

Heretofore, we have thought almost entirely in terms of the supervisory visit in the home, and have given little consideration to the larger purpose of supervision. While the supervisory visit with the individual nurse is important, I think we should look upon it more or less as our opportunity to study the needs of our particular staff, and so contributory to the more important side of supervision—namely, the developing of an educational plan that will draw out the best that is in our nurses, and allow for the exercise of initiative and executive ability. If our nurses are encouraged to think for themselves and to act as the result of critical thinking, we will not have much cause to worry over the future.

SUPPLY AND DEMAND OF PUBLIC HEALTH NURSES

By ESTHER M. BEITH, Director, Child Welfare Association, Montreal, Que.

Walter Lippman, Editor of the *New York Herald-Tribune*, in his address to the National Conference of Social Work held in Philadelphia last month (May, 1932), when discussing present economic conditions, made the following statement: "In the Western World at least we have solved the problem of scarcity. Our problem now is the management of plenty."

In attempting to review the question of Supply and Demand in reference to Public Health Nurses as dealt with by Dr. Weir in the Report of the Survey of Nursing Education, we are in spite of Dr. Weir's warning, tempted to use the interpretation of our individual opinions and experiences, rather than those of the Survey and the body of nursing facts as compiled under the direction of the Joint Study Committee. To this Committee every nurse and potential nurse in Canada owes a debt of gratitude.

Within the last few days, I have had the privilege of reading the excellent paper given to the Nursing Section of the Canadian Public Health Association by Dr. Mitchell, of the Mental Hygiene Institute of Montreal. Dr. Mitchell emphasizes the Survey Report's often reiterated statement for the lack of preparation public health nurses have for their teaching function, the function on which their entity depends. Judging by Dr. Mitchell's standard, I am tempted to assume that the supply of public health nurses in Canada is practically zero after taking part in the unlimited number of economy meetings held by the Public Health and Social Organisations in Montreal and having

a knowledge of applications on file in our own Organisation, I could almost question the existence of a demand. Therefore if this discussion were to be limited to my own interpretation and opinion of its title, the reasonable thing to do, would be to sit down and end this paper now.

SUPPLY AND DEMAND OF PUBLIC HEALTH NURSES

However, if you are to be denied this reward of my own rather pessimistic view we can turn to the statement of facts in the Survey Report. In 1929-1930 there were 1,521 nurses actively engaged in public health nursing in Canada. A number, which Dr. Weir states, was 20% below the demand at that time for the whole of the Dominion, and 40% below the demand in the Maritime Provinces. I think we can state that these 1,521 public health nurses, while realising the truth of the Report's and Dr. Mitchell's challenge as to their lack, with some few exceptions, of an adequate knowledge of teaching methods and Mental Hygiene, have created a demand which can absorb any qualified public health nurse existing in Canada today. This does not include every nurse who wishes to do public health nursing. Our problem still is the management of scarcity.

If we accept, as we should, Dr. Weir's interpretation of the present public health nursing situation, there should be a position in Canada today for 1825.2 public health nurses. Recently I secured information from the East Harlem Nursing and Health Service as to the number of families that they allotted to each nurse in their generalised Public Health Nursing

(Read at the Public Health Nursing Section, Canadian Nurses Association General Meeting, June 24, 1932.)

scheme. This was from forty to forty-five families — approximately 250 individuals and this is a congested urban area. Many of our Victorian Order of Nurses are giving this type of service but I fear not on the same numerical basis.

If we could apply East Harlem standards of service to Canada, even without any discrimination in favour of our rural areas, we might interpret our public health nursing needs in a somewhat more generous manner than that of the Survey Report.

One of our foremost public health authorities places the percentage of our population outside the scope of such nursing service as 5%. The figures in the Report are based on a population of 10,000,000. Taking this figure with East Harlem standards our present need for public health nurses would be 34,000. An Utopian idea, you would gasp, and yet at the time of the Survey there were, including students in training, 30,510 nurses in Canada—one for every 327 individuals. Our problem now seems the management of plenty.

In the event of the socialisation of our medical and nursing service, which some of us think, with the Survey Report, is not so far distant, would the function of any large number of nurses be absolutely outside the public health nursing field. Hospitals and institutions are even now recognising the value of the socialised training of public health for many of their positions. However, from 1,825 to 34,000 is a long step. We are quite aware that the need on such a basis is greater than the demand.

We might go still farther in attempting to disagree with the Survey Report's estimate of the demand or rather to advance it five years. I think most public health organisations feel that they might double their present nursing staff

at once, if they were not limited by lack of available funds. This again would be the fallacy of individual opinion against compiled facts.

We turn to the economist, John Stuart Mill, who tells us that demand is not limited by means to purchase. It is limited by desire to purchase. It is only in time of crisis, due to lack of confidence, that if sufficient desire is present it does not consume the supply. Some of us who would have preferred to motor to Saint John feel that this is hard to believe! The supply of motor cars seems more than adequate, and we think we have the desire. Nevertheless, we came by train. We admit the crisis!

The economic crisis, methods of distribution and various other factors, are responsible for the greater part of the unemployment of our nurses today, but we still agree with the Report, though we know unlimited instances of people wanting nursing service and going without because they are unable to pay, that the production of nurses is greater than the desire for nursing service. Certainly in order to assimilate 34,000, the present public health nurse will have to create a desire for Health Education that it is more urgent than it is today.

Our problem in Health Education, especially in the nutrition field, is giving us excellent training in attempting to create a desire for things that people do not seem to want. Stew rather than roast beef and cod fish rather than salmon. It should be possible to persuade them to acquire their Health Education and Nursing Service from a qualified public health teacher rather than from their next door neighbours. In one instance we are endeavouring to create a desire for a cheaper article, in the other for a somewhat more expensive one, if judged by an immediate monetary value. If one may again use a personal experience, a desire

to spend seems easier to acquire than a desire to save.

When we speak of the supply and demand of public health nurses, we should ask ourselves: What are public health nurses and why should the community demand their services? The Survey Report tells us that an active public health nurse is one of 1,521 women whose median age is 37.4, who has spent 3.3 years in high school and whose median nursing experience is 8.8 years. Fifteen per cent have had normal school training, 93% have spent 36 months in a hospital training school; 7%, 30 months, and 58% have spent 9 months in taking special courses. The purpose for which the demand for this type of nurse's service exists, is the education of the community in healthy living, either through a bedside nursing programme or by straight health supervision and teaching methods.

Health as applied to living is too complex a problem for discussion here, even were I competent to discuss it. It is sufficient to say it evolves a physical, mental and social health programme, the inter-reactions of which are so involved that it is impossible to separate them. If we consider a health teacher in this broadest aspect, I think we will all admit the non-existence of an adequate supply.

At least 15 years ago, the public health nurse entered the field with her attention directed toward physical health problems. Her preparation was that given to her in her training school, plus leadership from certain physicians and nurses who had vision to see beyond a curative programme, back to prevention of disease and then to positive health. Her success—for she has been successful if our means of judging the results of her work are accurate, and in general I do not think any have dared question them—was due rather to her per-

sonality, her prestige as a nurse, plus factual material. She superimposed her ideas on individuals and persuaded or dragooned them into certain health measures, but this was not health education. She soon found that she was confronted with a task for which she was educationally totally unfit, as the Survey Report might suggest — she was born but not made. In the last fifteen years much has been done to improve this situation. Nevertheless the supply of nurses qualifying themselves by university post graduate course has been quite inadequate to meet the demand for their service. This year it is true many organisations have been forced to refuse qualified applicants not because they are not required, but due to the fact that during times of scarcity Public Health organisations employed unqualified nurses. These nurses, having filled the breach in prosperous times cannot, in fairness, be turned back into the present overstocked private duty or institutional fields.

If qualified public health nurses are unemployed it is due to a problem of management and distribution. The demand still exists and will exist increasingly if, as the Survey Report states, vigorous and enlightened leadership is available.

When we speak today of a qualified public health nurse, we refer to the nurse whose educational attainments are such that she has been admitted to, and received a diploma from, a university post graduate nursing school. Such schools have recognised her need for training in teaching methods, in mental hygiene and sociology—nine months is a short period. We agree with most of our nursing education leaders that if the public health nurse is to compete educationally in the field, with certain allied professions, she must qualify for and be given a degree.

Since coming to the Convention,

listening to Professor Fraser and hearing other discussions by nursing educationists, I would like to qualify the above statement. I am not a leader in nursing education and my opinion is coloured somewhat by personal experience. For the last two years in Montreal we have established a Health Service for twenty-six of the thirty-two agencies in Financial Federation. These agencies are staffed by social workers, the majority of which are demanding of their staff a Bachelor or Master of Arts degree, plus two years in a recognised school of social work. The physician, the public health nurse, the nutritionist and the social worker meet together in a joint health (I speak of health in the broadest aspect) programme for the family. We feel that the public health nurse's contribution to health as a

whole is at least of equal importance to that of allied groups. I am not particularly interested in degrees as such, merely pleading for an educational standard.

Those of us who are working in the field today, even without Dr. Mitchell's and the Survey Report's warning, are thinking seriously as we venture into adult group education, into mental hygiene, into social problems from which no public health nurse can divorce herself—are we going to measure up to the demand which has been created? The health teacher of the future is confronted with the task of at least participating in the mental and social health field as well as the physical, and the serious idea for us to think over is the fact that much of the demand of the future depends on how the present supply functions.

BOOK REVIEW

SCHOOL NURSING: A Contribution to Health Education by Mary Ella Chayer, Instructor in the Nursing Education Department, Teachers College, Columbia University. Published by G. P. Putnam's Sons, Knickerbocker Press, New York City, 1931. Pages 285. Price \$2.50.

The strength of this book, and its distinctive contribution, lies not so much in the outlining of methods and procedures used by the public health nurse in school health work, but rather in the portrayal of a sound philosophy concerning school nursing and its relation to the school child. With penetration and discernment, the author thinks beyond the daily practices of the school nurse to a discussion of educational principles governing those procedures, and beyond that again to a sound philosophy of such practice. Nor is that all. In a study of the relation of the nurse to the school child her approach is a scientific one. From a wide range of source material she brings to bear upon the subject the most recent findings of scientific research. The author argues throughout for the integration of all services focussing upon child health and for a point of view which considers the child not only in terms of school, home and community relationships, but of life itself.

The book comprises twelve chapters in all

with a comprehensive bibliography. Several appropriate illustrations are included. The first chapter deals with the historical background of the subject, tracing something of the evolution of public health nursing and its emergence from visiting nursing. The student of history could have hoped for more pages given to that aspect of the subject. The chapter on Principles of Education as Applied to the School Nurse includes the topics: Purposes of Education, Criteria for Evaluating Activities and the Changing Concept of Health. Of equal value is a chapter on the Factors of a Healthful School Environment. A third one, The Health Inventory, gives consideration to the Health Examination, to Dental Hygiene and Nutrition and to Trends in Weighing and Measuring. A chapter is devoted to each of the following: Nursing in Secondary Schools; Parent Education; Relationships within and without the School.

All told the work is a timely addition to the documentation on this subject. Moreover, it is the result of a wide experience in sound, progressive practice and is commended to the attention of those engaged in this branch of public health nursing.

F. H. M. E.

International Council of Nurses

Nurses in Canada who are planning on attending the Congress, International Council of Nurses, July 10-15, 1933, in Paris and Brussels will be interested to learn that arrangements have been made by the Canadian Nurses Association through Thos. Cook & Son, Travel Agency, for a sailing to be made on the Empress of Britain on July 1st.

The complete individual fare for what may be termed the official tour from Montreal back to Montreal will be \$280.00. The return will be made on the Duchess of York, sailing from Liverpool on July 21st. Arrangements can be made for those who wish to leave Canada before July 1st as well as for those who may want to remain abroad for sometime following the Congress. This, of course, will mean additional expenditure to the above quoted rate.

Following the close of the Congress this tour will include an excursion to Waterloo from Brussels on July 16th. The following day the party will travel to London via Ostend and Dover. July 18th to 20th will be spent in London for sightseeing, also an excursion to Windsor Castle, etc. Departure by rail for Liverpool is scheduled for Friday, July 21st, from where the party will sail for Canada on the Duchess of York.

The inclusive fare is based on a party of at least 25 members. From the responses coming in to National Office since copies of the preliminary announcements were circulated, it is estimated there will be no difficulty in the party reaching the minimum required.

THE FARE INCLUDES:—

Steamship Accommodation: Stateroom berths on the Trans-Atlantic steamers, consisting of Tourist Class accommodation specially reserved for the party, and first-class on Cross-Channel steamer.

Rail Travel: Second-class on the Continent and third-class in Great Britain, which corresponds to Continental second-class.

Hotel accommodation at good comfortable establishments, particularly well chosen for the convenience to points of sightseeing interest and for the quality of accommodation provided. This includes room and breakfast in Paris and Brussels, (usual Continental breakfast, consisting of rolls and coffee), throughout the Congress period. This is in accordance with the special request made by the Congress Committee, as a number of official luncheons and dinners will take place which no doubt most of the nurses will want to attend, and furthermore, the daily sessions of the Congress will be all-day affairs, resulting in inconvenience to the nurses if they have to return to their own hotels for meals. All meals will be provided en route between Cherbourg and Paris, Paris and Brussels and Brussels and London. In England, breakfast will consist of a full meal, with meat or eggs and table d'hôte lunches and dinner.

Sightseeing: An excellent programme of sightseeing is included. Visits will be made by sightseeing automobile to the principal

places of historic, literary and scenic interest, and the leading museums and galleries.

A Tour Manager will be provided to travel with the tour from arrival at Cherbourg on July 6th to embarkation for Canada at Liverpool on July 21st and will take charge of the pre-arranged sightseeing and excursions, the travel arrangements of the tour, and will generally assist the members of the party in making any private arrangements they may wish.

Fees or tips to hotel servants, porters, chauffeurs, etc., while accompanied by the Tour Manager, also admission to public buildings, museums, etc., are included.

Transfers of passengers' baggage between railroad stations and hotels, or piers, are included.

Baggage: Members should take as small an amount of baggage as possible, a standard suit-case or any ordinary suit-case will be carried free of cost. Members may take an over-night handbag containing the necessities of travel for use on trains and local steamers, which must be carried and transferred, by and remain under to the control of the owner at all times.

Taxes on travel and hotel accommodation as at present imposed by the governments of the countries visited, are included.

THE FARE DOES NOT INCLUDE:—

Expenses of passports and visas, laundry, wines, mineral waters, after-dinner coffee or food not on the regular menu, the expenses of carriages, automobiles, guides or sightseeing not specified in the itinerary, or ordered by the Tour Manager, or baggage insurance, which is strongly recommended.

An earlier sailing can be made from Canada, on S.S. Duchess of Richmond, from Montreal on June 16th arriving in Glasgow, June 23rd. The following day the party will travel to Edinburgh by way of the Trossachs, by rail, coach and steamer. After two days in Edinburgh, by rail to to Keswick via Carlisle, then by motor coach to Ambleside for one day. Travel to Windermere and Chester will be by coach on June 29th. The party will have a morning in Chester, then on to London, arriving there the afternoon of June 30th.

Canadians could not wish for a more enjoyable July 1st week-end than one in London which in this itinerary would extend to Tuesday evening, July 4th. Travel to Paris will be made via Folkestone and Boulogne on July 5th—this arrangement allows for four days in Paris previous to the opening of the Congress on Monday July 10th. Those wishing to return at once to Canada can arrange to sail from Antwerp on Saturday, July 15th.

As the Canadian Nurses Association has undertaken to co-operate with Thos. Cook & Son in transportation arrangements for nurses from Canada it will be advisable for members of the Canadian Nurses Association to make their reservation for accommodation through the organisation.

News Notes

Contributors to this Section are reminded that the address of the Journal is now 401 Crescent Building, Montreal, Que. Copy for this Section should reach the Editor not later than the twelfth of each month for ensuing issue.

BRITISH COLUMBIA

Results of Examination for Registered Nurse's Certificate

An examination for Title and Certificate of Registered Nurse was held recently throughout the province with the following results:

133 wrote the examinations.

116 passed.

6 passed with supplementals to write.

4 passed Supplemental Examinations.

Standing in order of merit:

First Class—80% and over;

Misses: F. L. FERGUSON, Royal Jubilee Hospital, Victoria.

I. M. COPE, Vancouver General Hospital.

B. S. MOODY, Vancouver General Hospital.

W. BOND, Vancouver General Hospital.

M. A. C. P. CLARK, Port Simpson General Hospital.

H. M. KEIVER, Vancouver General Hospital.

M. A. EDWARDS, Vancouver General Hospital.

Second Class—65% to 80%:

Misses W. M. Gowen, L. B. Hunter, V. M. Porter, R. J. Orr, M. J. MacDonald, (E. K. Simpson, E. D. L. Luesing, S. E. Freeman and A. C. MacKenzie—equal), E. A. A. Hiles, (M. R. Smith and R. B. MacLellan—equal), M. M. Keary, E. L. Cudmore, N. C. Bennett, F. C. Jostad, I. N. McQuarrie, M. B. Butchart, M. Robertson, H. A. Becker, M. M. Downey, (I. McLachlan, K. R. Begg, M. A. Baynes and J. I. Campbell—equal), J. M. Hunter, (M. C. Miles and G. McFadyen—equal), H. L. Holliday, (M. L. Smythe, L. M. Chase and M. E. Hammond—equal), (M. Burkhart and M. S. Hartley—equal), N. V. Lee, (K. Ringshaw and S. N. Keillar—equal), (Mrs. F. A. Thompson and M. Elliott—equal), (M. J. Murdoch and J. F. Home—equal), (W. M. Chapman and A. M. Laidlaw—equal), (M. R. Duff, C. J. Tremeer and N. J. Richardson—equal), M. E. L. Fraser, (M. A. Calhoun and G. M. Jones—equal), A. D. R. Grant, (A. L. Dickinson, E. K. Stady, D. E. Tate and E. S. Lemm—equal), J. E. Hill, (T. M. Hopkins and C. M. Laidlaw—equal), C. M. Todd, E. J. Ryan, M. E. Moffat, A. M. Sylvester, (M. K. Earle and V. E. Taylor—equal), E. C. Duffield, (G. E. Macrae and M. P. R. Munro—equal), C. E. Cornell, M. L. Parson, (J. W. L. Smith, G. M. Forrest and M. M. Allaire—equal), (M. M. Ferguson

and E. M. Rathie—equal), M. E. Wilson and H. B. M. Holmes—equal), E. L. Buckley and S. Lebedovick—equal), A. L. Lancaster, G. Dawson, F. I. Moore, (I. M. Dale and O. M. Huggins—equal), E. A. Alexander and E. B. Schroeder—equal).

Passed—60% to 65%:

Misses (O. M. Haggman and G. M. Jones—equal), I. C. Pike, H. W. Stevenson, C. G. Nueich, T. D. Green, A. A. Swanlund, I. I. Cumming, P. L. Madill, (J. I. Gray and V. Waram—equal), E. M. McDiarmid, (M. P. Dobbie and D. E. Stewart—equal), N. V. Waind, (D. R. Corble, M. P. Jones and P. A. Murphy—equal), J. I. Stewart, B. R. Merrill, (V. deBlaquiere, I. Craig, A. M. Elliot, E. F. Lord and I. A. McGarrigle—equal).

Passed Supplemental Examination:

Misses H. K. Beckett, L. I. Buckmaster, N. E. Foster, I. Morgan.

Passed, with Supplemental to write:

Misses F. L. Fletcher, M. Gilbert, M. I. Mackenzie, Mrs. B. L. Mackie, W. M. Robillard, L. M. Somerville.

GRADUATE NURSES ASSOCIATION, VICTORIA: The V.G.N.A. held a regular monthly meeting at the Nurses' Home, Royal Jubilee Hospital, on November 5, 1932. The meeting was well attended, in spite of the inclemency of the weather and an epidemic of colds. After the routine business of the month, the Private Duty Section took charge of the programme. Chapter Five of the Report on the Survey of Nursing Education in Canada was studied. The study was synoptical. Several of the members had prepared papers giving a synopsis of the principals involved in each paragraph, in this way giving a general review of the chapter. A round table discussion on the chapter was led by Miss L. Mitchell, Director of Nursing, Royal Jubilee Hospital. It is the intention of the Association to study sections of the Survey Report in this manner, at regular meetings throughout the winter.

JUBILEE HOSPITAL, VICTORIA: The regular business meeting of the Alumnae Association was held in the Nurses' Home, September 19. Owing to the resignation of the president, Miss Elise Oliver who is to be married in the near future, Miss Jean Moore was appointed to that office. The programme for the winter was discussed, plans for which were left to the Entertainment Committee. A special effort is to be made along social lines, thus endeavouring to interest younger members of the Association in their Alumnae.

MANITOBA

BRANDON: The regular meeting of Brandon Graduate Nurses Association was held on November 1, 1932, at the Nurses' Home, General Hospital. Much important business was discussed and as a result the new schedule of fees was arranged for private duty nursing. Fees for private duty will be \$3.00 for 12-hour duty and \$3.50 for 24-hour duty. A fee of fifty cents will be charged for hourly visits and where the visit is prolonged the fees will be adjusted by the nurse herself. The registration fees for private duty nurses were reduced to \$2.00. During the evening Miss Jean Houston, President, Manitoba Association of Registered Nurses, gave an interesting report of the Biennial Meeting of the Canadian Nurses Association. The report dealt with various sections of the Report on the Survey of Nursing Education in Canada. At the close of the meeting refreshments were served by the General Hospital Group.

CHILDREN'S HOSPITAL, WINNIPEG: The first general meeting of the Children's Hospital of Winnipeg Alumnae Association was held in the Nurses' Residence, on October 21, 1932. The election of officers was as follows: President, Miss Catherine Day; 1st Vice-President, Miss Edith Jarrett; Secretary, Miss Elsie Fraser; Treasurer, Miss M. Hughes; Committees: Entertainment, Mrs. George Wilson; Sick Visiting: Miss M. Atkinson and Miss H. Clarke; Refreshments: Miss A. McAully. A hearty vote of thanks was tendered the retiring President Mrs. George Wilson, for her untiring efforts during the past years. Plans were discussed for the activities during the coming year, and various means by which funds might be raised. A social hour followed.

ONTARIO

APPOINTMENTS

PROVINCIAL DEPARTMENT OF HEALTH: Miss Gladys Motley, graduate of the Public Health Nursing Course, University of Toronto, 1932, commenced her duties in Haileybury in October. She is replacing Miss Florence Farr, who resigned to take the Public Health Nursing Course at the University of Western Ontario, London. Miss May E. Hamilton has been appointed to the school nursing staff of Port Arthur, beginning her duties at the opening of the school term. Miss Hamilton, a resident of Port Arthur, is a graduate of the Public Health Nursing Course, University of Toronto, 1932. Miss Christine M. McLaren, graduate 1931, from Course Two, University of Toronto, has succeeded Miss Hazel I. Atkinson as public health nurse in Perth. Miss Petronilla Schurter has been reappointed school nurse in the Separate Schools, London. Miss Maud C. Weaver is engaged for temporary service as public health nurse in Orangeville. Miss Weaver was in Chapeau from January to June, the service there being discontinued for

financial reasons. Miss Hazel I. Atkinson has been appointed public health nurse at Kirkland Lake, replacing Miss Campbell, who resigned to be married. Miss Maud Campion, public health nurse, Department of Health, Brantford, has resigned her position. Her marriage took place October 29th. Mrs. Margaret Norton, graduate of Public Health Nursing Course, University of Toronto, 1932, succeeds Miss Campion. Miss Edna Squires, Provincial Public Health Nursing staff, is assisting the Wellington County Health Association to carry out a Tuberculosis Survey.

DISTRICT 1

Members of R.N.A.O. District No. 1, held a very interesting and instructive meeting in the Nurses' Home of St. Joseph's Hospital, London, on September 17, with Miss P. Campbell, Chatham, President, in the chair. This meeting followed a short refresher course in "Maternal Care" at the Public Health Institute, London, under the direction of Miss Cryderman of the Victorian Order of Nurses Staff in Ottawa, and Miss Marjorie Bell, Director of Visiting Housekeepers' Association, Toronto. Splendid addresses by the Most Rev. J. T. Kidd and Right Rev. C. A. Seager, Bishop of Huron, added much to the meeting. A report of the Biennial Meeting of the Canadian Nurses Association in Saint John, was given by Miss Agnes Mallock, London. Miss Mary Millman, President of the Registered Nurses' Association of Ontario, as guest speaker, impressed the value of membership in R.N.A.O. Miss Millman gave six reasons:

1. Because of service rendered the public through a study of Community problems an attempt is made to keep each nurse in step with her profession.
2. Because of the protection offered the individual nurse through group effort. Registration in Ontario could not have been accomplished without a co-operative and organised effort on the part of the Nursing profession.
3. Because of group development made possible through affiliation with Nursing bodies,—national and international—and through opportunities afforded for group conferences and educational projects.
4. Because the nurse who withholds membership is accepting benefits derived from an organisation in the support of which she has not shared.
5. Because the Provincial Association needs the help as well as the fee of the individual nurse.
6. Because it is only through membership in a provincial association that a nurse may become a member of the Canadian Nurses' Association and the International Council Council of Nurses.

Following Miss Millman's address a very instructive lecture was given by Dr. G. K. Wharton, London, on "The Medical Patient." The nurses of District No. 1 are concentrating

on Group Effort for the purpose of raising their 1932 quota to the Permanent Education Fund. Miss Ella Moffatt, Royal Victoria Hospital, Montreal, and recent night superintendent of the Ross Pavilion, R.V.H., has accepted the position of assistant superintendent of the Public General Hospital, Chatham. Miss Grace McKerracher, resigned her position as public health nurse of the Public General Hospital, Chatham, on September 15, 1932, and is succeeded by Miss Jean Coatsworth, graduate of the P.G.H. Chatham.

DISTRICT 2

BRANTFORD: Miss L. Gillespie and Miss D. Arnold of the staff of the Brantford General Hospital, attended the Staff Nurses Refresher Course at the University of Toronto, November 7-12, 1932.

GUELPH: Miss Agnes Campbell attended the Ontario Hospital Association Convention held in Toronto, October 26-28. Miss Kenny is again helping the Red Cross Society with lectures in Practical Nursing held each week at the Y.W.C.A. Miss A. Campbell and Miss Groenewald motored to Chatham recently and spent a short time with Miss Priscilla Campbell, at the Chatham Public General Hospital. Her friends are pleased that Miss Zeigler is much improved after having had a very serious illness.

DISTRICT 4

The regular quarterly meeting of District No. 4, of the R.N.A.O. was held on October 15, 1932, in the Y.W.C.A. in St. Catharines, the Chairman, Miss A. Wright, of St. Catharines presiding. A report of Biennial Meeting of the Canadian Nurses Association, was given by Miss Margaret Buchanan, of Hamilton. Miss Jean Gunn, Superintendent of Nursing, Toronto General Hospital, spoke on "What are We Doing With the Survey?" Miss Gunn stressed that each nurse must do her part in helping to realise the recommendations brought forth in the Survey Report, otherwise very little could be accomplished.

DISTRICT 5

TORONTO—Instructor's Section of the Centralised Lecture Course: A meeting of the Instructors' Section of the Centralised Lecture Committee for Student Nurses was held on November 3rd at the Nurses' Residence, Hospital for Incurables, Toronto, 20 members being present. Miss Nora Nagel, of the Hospital Instructors' and Administrators' Course, Department of Nursing, University of Toronto was the guest speaker. Her subject, "Self Examination in Ways of Teaching" was most interesting and instructive. Following the address, various members brought forward problems for discussion. Miss Nagel suggested as a project, that a study group be formed for the purpose of contributing towards the History of Nursing in Canada. Miss M. Dulmage was appointed convener of a committee to study various eras of nursing in Canada. It was recommended that a com-

parison of the various text-books on Anatomy be made and an understanding as to what is to be considered essential information to be taught. It was decided to have a meeting of those particularly interested in the teaching of Anatomy and Physiology before the next general meeting. At the close of the business meeting, Miss Cook, Superintendent, was hostess to the group at a social hour.

Community Health Association of Greater Toronto: The annual meeting of the Community Health Association of Greater Toronto was held in Osler Hall, Academy of Medicine, October 31, 1932, the President, Miss Ruby E. Hamilton, in the chair. The reports indicated a healthy, growing organisation with 110 paid-up members. About fifty members had enrolled in the courses in Parent Education arranged by the Pre-School Committee. The Association had the privilege of hearing outstanding speakers during the year, namely, Miss Mabel Cartwright, Dean of St. Hilda's College, Trinity College, Toronto; Dean Tri-vett, of Holy Trinity Cathedral, Shanghai, China; Dr. Horace Speakman, Director of the Ontario Research Foundation, and Mrs. S. Harriet Mitchell, Director of Parent Education, Mental Hygiene Institute, Montreal. Officers for the coming year were elected as follows: President, Mrs. W. George Hanna; First Vice-President, Miss Helen Hefferman; Second Vice-President, Miss Mildred Mann; Secretary, Miss Elda Rowan; Treasurer, Miss M. Gordon Lovell; Councillors, Misses Lillian Barley, Laura Gamble, Ruby Hamilton, Edna Moore, E. Mildred Sellery and Muriel Winter. The speaker of the evening, Professor G. R. Jackson, Supervisor of the Study Course in Commerce and Finance, University of Toronto, spoke on "The Causes of the Present Depression," chief of which are war debts, high tariffs, and foolish investments. To the last-named cause even the small investor had contributed. A pleasant social time brought the meeting to a close.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Alice Vernon and Miss Stella Hodge, 1926, have returned to Toronto after spending some weeks abroad. Miss Beatrice Shuttleworth is now on the staff of the Out Patients' Department. Miss Grace Woodall, 1930, has gone to Timmins and is doing private duty nursing there. Dr. and Mrs. D. T. Kendrick (Irene Newcombe, 1928,) have moved to Regina, Dr. Kendrick being in charge of the trachoma cases for the Province of Saskatchewan. Miss Laura Rowntree, 1930, who spent some weeks touring in Western Canada, has resumed her duties in the X-ray Department. Miss Marie Grafton, 1928, has returned home after three months at the Coast and in California. Miss Margaret Tanton, 1928, spent her holidays in Southern California. Miss Kathleen Panton, former Superintendent of Nurses, H.S.C. is spending the winter with her brother Dr. Panton, in Vancouver. Miss Doris Bews, 1928, is visiting friends at the Coast. Miss Margaret McInnis, 1928, who is in charge of Ward E at Toronto General Hospital, took a short trip

abroad this summer. Dr. and Mrs. Jack Lind (Elsie Hinds, 1929) are spending the winter in England, before going on to resume their new duties in China., where Dr. Lind will be on the staff of one of the missionary hospitals under the United Church of Canada. Miss Reba Simpson who was awarded the Alumnae Scholarship this year is attending the University of Toronto and taking the Public Health Course. Miss Jean Morrison, 1927, is now on the staff of the Preventorium Hospital in Toronto. The Association trusts that Miss Irene Wilson, 1928, is recovering after her accident and that Miss Susan Welsh, 1928, is making a satisfactory recovery following her serious illness. The sincere wishes of the Association for a speedy recovery are extended to Miss Gertrude Evans, 1927, now of the Vancouver General Hospital.

TORONTO WESTERN HOSPITAL: Activities for fall and following months with the Alumnae Association have commenced. Contributions to the programme consist of Reports from the C.N.A. Biennial Meeting held in Saint John, N.B., and a talk on "Hypertension" by W. W. Priddle, B.A., M.D.

DISTRICT 8

A general meeting of District No. 8, R.N. A.O. was held in the Nurses' Residence, Civic Hospital, Ottawa, November 4, 130 members being present. The meeting was opened at 9.45 a.m. with Miss Percy, Chairman, presiding. Interesting reports were read on the C.N.A. meeting in Saint John. A Study Committee was formed to make a further study of the Survey Report. The question of unemployment among nurses was discussed and a committee appointed to make an investigation regarding conditions. An address by Dr. L. P. MacHaffie on "The Problem Child of Pre-School Age," followed by an address on "The Problem Child in School", by Miss Florence Dunlop, M.A., of the Public School Staff, proved of great interest and was enjoyed by all present. During the luncheon when the nurses were guests of the Trustees of the Civic Hospital, Dr. B. T. McGhie, Director of Hospital Services for Ontario, spoke on "Opportunities for Nurses in the Field of Mental Nursing." The afternoon meeting was addressed by Dr. Cathcart who chose for his subject "Mental Hygiene and the Nurse."

QUEBEC

HOMEOPATHIC HOSPITAL OF MONTREAL: Miss M. Anderson, 1931, has recovered from her recent operation and has resumed her duties as night supervisor of the Case Room, H.H.M. Following a major operation in June, 1932, Miss A. Pearce, 1924, resigned her position as night superintendent, H.H.M., and has accepted an appointment to the Grace Dart Home Hospital in Montreal. Miss T. J. Whitmore, 1925, succeeds Miss Pearce. Miss H. Forbes, 1931, recently underwent an operation for appendicitis and is now convalescing at St. Eugene, Ont. Miss G. Crossfield, 1925,

recently underwent an operation and is making satisfactory progress. The staff held a surprise bridge recently in honour of the Misses A. R. Oney and I. A. Hicks at which both brides-to-be were presented with coffee percolators. The Alumnae Association extends to Miss M. Anderson, 1931, and her family sincere sympathy in the loss of her father. Miss M. Currie has returned from a visit to Amherst, N.S.

C. A. M. N. S.

TORONTO: The annual meeting of the Overseas Nurses' Club of Toronto was held at the Nurses' Residence, Christie Street Hospital, on October 5, with about seventy members present. Everyone was glad to see Miss Hartley who returned to duty on September 1st after a long illness. Report of the various committees were received and plans for the coming year discussed. Miss Wilkinson who had represented the club at the meeting of the All Canada Association held in Saint John at the convention of the C.N.A., gave a report of the session where business of the Association was discussed and officers elected. It was resolved that the Toronto Club request the All Canada Association to place a wreath on the Nurses' Memorial in the Parliament Buildings at Ottawa on Armistice Day. Officers for 1932 and 1933 were elected as follows: President, Mrs. Jack Bell (re-elected); Vice-President, Miss Meiklejohn; Corresponding Secretary, Mrs. McKay (re-elected); Recording Secretary, Mrs. Ross Craig; Treasurer, Mrs. Hanna. Refreshments were served at the close of the meeting and a social half hour provided opportunity for renewing old acquaintances. On a recent Saturday afternoon Miss Edith Campbell (Matron), Miss Meiklejohn, Mrs. Bell and Mrs. McKay motored over to Hamilton to meet Miss Rayside, the newly elected president of the All Canada Association, and discuss various plans of interest for the future.

MONTREAL UNIT

Members of the Montreal Unit, Overseas Nursing Sisters Association of Canada, assembled once again on Remembrance Day at the dinner hour. The annual dinner reunions are becoming more popular as the years roll on, this year's event being the largest group assembled since the nursing sisters returned home. The musical programme was, as usual, ably conducted by the inimitable Jimmy Rice, who this year provided additional pleasure through the golden voiced tenor of radio fame, Jack Vanderstraten. The latter sang many of the well known English, French, Italian and Spanish "gems" and joined in the community singing of the old war-time favourites. The toast to His Majesty, the King, was proposed by the Acting President and Chairman, Miss Claire Gass, and the following lines in memory of those with whom the members meet in spirit only, which were written by one of the members (Winnifred Fray Ramsay), were read by E. Frances Upton.

"WE REMEMBER"

Beloved friends, who gently rest
 Beneath God's earth
 In far off lands,
 Come near, with wings of joy and love.
 Sweet comfort bring
 To weary souls,
 On this Remembrance Day.

We wear your poppies near our hearts,
 And the clear vision see
 Of your eternal love.
 We touch with reverence every petal red.
 Memories enshrined
 Of our Immortal Dead.
 On this Remembrance Day.

And then "The Silence" where our spirits
 meet,
 You are so near,
 So very dear,
 Again, we tread together, the paths of long
 ago.
 'Twas yesterday.
 'Tis now today.
 On this Remembrance Day.
 The bugle sounds, and to our unfinished
 tasks
 We turn, refreshed.
 With power possessed.
 Filled by the presence of your calm content,
 Of work well done.
 Of glory won.
 On our Remembrance Day. —W.F.R.

BIRTHS, MARRIAGES AND DEATHS**BIRTHS**

COLLISON—On June 28, 1932, at Victoria, B.C., to Mr. and Mrs. R. L. Collison (Lorna Colbourne, Jubilee Hospital, Victoria, 1928), a son.

HOPE—On October 8, 1932, at Saskatoon, Sask., to Mr. and Mrs. Earnest Hope (Mabel Cunningham, Guelph General Hospital, 1928), a daughter.

KNIFFEN—Recently in Montreal, to Mr. and Mrs. L. Kniffen, (Jean Burrill, Homœopathic Hospital of Montreal, 1930), a son (Leslie Daniel).

LOVE—On August 16, 1932, at Victoria, B.C., to Mr. and Mrs. J. Love (Hazel Jones, Jubilee Hospital, Victoria, 1927), a daughter.

RETALLICK—Recently, in Montreal, Que., to Mr. and Mrs. M. Retallick (Marie K. Nuise, Homœopathic Hospital of Montreal, 1925), a daughter (Doris Norma).

SAMPLE—On September 26, 1932, at Chatham, Ont., to Mr. and Mrs. Clarence Sample (Margaret Gibson, Public General Hospital, Chatham, 1930), a daughter (Elizabeth Wilson).

WRINCH—On April 30, 1932, at Hazelton, B.C., to Dr. and Mrs. L. B. Wrinch (Frances Johnson, Jubilee Hospital, Victoria, 1929), a daughter.

MARRIAGES

ADAMS—ALBUTT—On August 2, 1932, at Victoria, B.C., Catherine Albutt (Royal Jubilee Hospital, Victoria, 1929), to Jack Adams, of Victoria.

BURKE—McKERRACHER—On October 12, 1932, at Chatham, Ont., Grace McKerracher (Public General Hospital, Chatham, 1924), to Thomas Burke.

CARR—ROBINSON—On September 27, 1932, at Toronto, Ont., Olive M. Robinson (Toronto Western Hospital, 1930), to William Harding Carr.

CAVANAGH—McININCH—On October 27, 1932, at Ottawa, Ont., Bernice McIninch (Ottawa General Hospital, 1929), to Dr. J. V. Cavanagh, formerly of Ottawa, now of Halifax, N.S.

CAVAYE—KERR—On September 9, 1932, at Victoria, B.C., Maeford E. Kerr (Royal Jubilee Hospital, Victoria, 1928), to Douglas Cavaye, of Chilliwack.

CHARTIER—McCARRON—In October, 1932, at Guelph, Ont., Marie McCarron (St. Joseph's Hospital, Guelph, 1929), to Leo Chartier, of Guelph, Ont.

CONNORTON—LAMB—On April 26, 1932, at Victoria, B.C., Frances Lamb (Royal Jubilee Hospital, Victoria, 1929), to Claude Connorton, of Vancouver.

DIES—ONEY—On August 2, 1932, at Montreal, Que., Almata R. Oney (Homœopathic Hospital of Montreal, 1930), to A. S. Dies. Residing in Montreal.

DWYER—FITZPATRICK—In October, 1932, at Toronto, Ont., Cecilia Fitzpatrick (Hospital for Sick Children, Toronto, 1928,) to Fred Dwyer, of Toronto. Residing in Chatham, Ont.

FLETCHER—EDE—On September 2, 1932, at Victoria, B.C., Wilburta Ede (Royal Jubilee Hospital, Victoria, 1929), to Walter Fletcher, of Victoria.

GILL—OVANS—On October 12, 1932, at Listowel, Ont., Margaret Merle Ovans (Brantford General Hospital, 1930), to Walter Allen Gill, of West Monkton.

Due to lack of space a number of Marriage Announcements are held over for next issue.

—Ed.

DEATHS

BREBNER—On November 9, 1932, at New York, N.Y., Dr. W. B. Brebner, beloved husband of Mildred J. Davidson (Toronto Western Hospital, 1923).

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

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